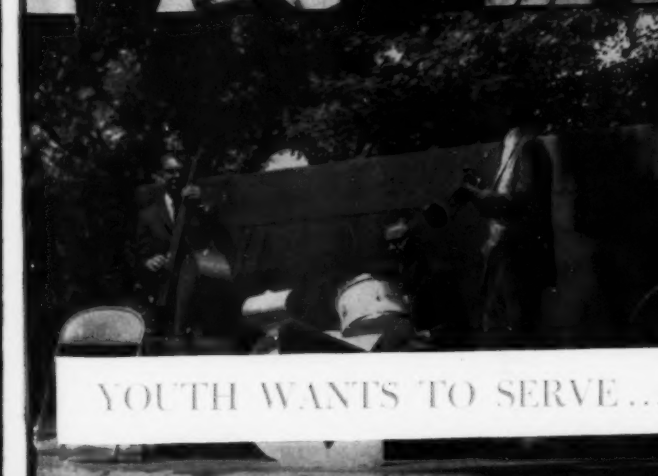
NURSING

January 1961

# Mental Hospitals

Hospital Journal
of the American Psychiatric Association





YOUTH WANTS TO SERVE ... *see page 14*

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## *Contents, January 1961*



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# *A Proposal* for Mental Hospital Reorganization

# THE KANSAS PLAN

By GEORGE W. JACKSON, M.D., *Director*
and FRANK V. SMITH, M.D., *Assistant Director*
*Division of Institutional Management*
*Kansas State Department of Social Welfare, Topeka*

THE KANSAS PLAN calls for reorganizational changes in the three mental hospitals of the state, and in the districts which they serve. It is believed that through implementation of this plan, the hospitals can serve the population more effectively and economically and at the same time provide an extension of their services to the communities.

A portion of the Kansas Plan was inspired by "The Clarinda Plan,"[1] following a visit to the Mental Health Institute in Clarinda, Iowa, by one of the authors, who was deeply impressed by the enthusiastic attitudes of the staff and the potential for better care and treatment for mentally ill patients.

Kansas has three state mental hospitals—at Topeka, Osawatomie, and Larned. The first state hospital building was completed in 1866, in Osawatomie. The next to open was Topeka State Hospital, where the first patient was admitted in 1879. The newest hospital, Larned State, was opened in 1913.

Since the "revolution" of 1948 when there was an exposé of the dreadful conditions in the Kansas mental hospitals, there has been continuous and dramatic improvement in the care and treatment provided in these hospitals. During the past decade, the average daily population for the three mental hospitals has been reduced from 4,934 in 1950 to 3,412 in 1960, while three times as many patients have been admitted. Waiting lists for admission have been essentially eliminated.

The Kansas State Board of Social Welfare has established three districts, one for each of the mental hospitals. These districts were established on the basis of population and geographical location in such a manner that each of the mental hospitals would serve an equal number of the population. The districts were set up so that the counties included were as close as possible to the hospital in order to reduce the distance patients had to travel for treatment. There is one large city in each hospital district. Roughly, the northeastern part of the state is served by Topeka State Hospital, the southeastern part by Osawatomie State Hospital, and the western part by Larned State Hospital.

Over the past decade, in spite of many difficulties, the hospitals have been able to develop enough staff to change the hospitals from custodial institutions to active treatment centers, where outpatient as well as inpatient care is given. Many things have contributed to this growth, two of the most important being the development of the psychiatric team and the section plan. These changes were completed in 1956 and have been in operation since that time.

## THE SECTION PLAN

The section plan was born and first developed at Topeka State Hospital. It varies somewhat in the three mental hospitals, but retains the essential concepts. Two of the hospitals still have separate units for geriatric patients, and all hospitals have units segregated by sex.

The biennial report for 1950 states:

". . . Sectional treatment teams have been organized, which consist of a psychiatrist, psychologist, social worker, nurse, occupational and music therapist, and psychiatric aides. These all work and confer together to bring their skills and attitudes to bear for improvement of the patient. . . ."

The next biennial report in 1952 further describes the section plan:

"In contrast to the organization of most mental hospitals where there is usually an admissions service, an acute treatment service, a chronic service, etc., this hospital is organized into four sections, each of which is staffed with a complete psychiatric team made up of psy-

[1]*Garcia, Leonard B.: The Clarinda Plan: An Ecological Approach to Hospital Organization, Ment. Hosp. 11: 9: 30-31 (Nov.) 1960.*

chiatrists, psychologists, social workers, nurses, aides, adjunctive therapists, etc. Patients are admitted to and discharged from each of these sections. They usually remain on a given section for the entire period of their hospitalization; thus the same group of staff personnel works with the patient throughout the course of his illness. Inasmuch as there is an active treatment program on each section, there is considerably less opportunity for 'back' wards to develop, and greater assurance is provided that all patients will get as much treatment as possible. This unique plan, the idea of Dr. Karl A. Menninger, prevents the shift of patients from section to section, interruptions in treatment as the patient must become adjusted to a new section and new personnel, and the development of 'forgotten' or neglected wards."

Although the section plan now used in the Kansas mental hospitals is a tremendous improvement over the previous state hospital organization, it still leaves much to be desired. At the present time the personnel of each section of each of the three mental hospitals are working with and have relationships with the personnel of all counties served by the specific hospital district. This also means that each probate judge, each county welfare department, each practicing physician, each nursing and boarding home, and every other agency associated with the hospital must work with four or five different hospital groups because they may have patients in each of the sections.

In January of 1960, a plan of psychiatric hospital reorganization was introduced by the staff of the Mental Health Institute at Clarinda, Iowa. Heretofore, this hospital had not been organized on the section plan, and so in one movement it adopted the section plan and went one step further by organizing the sections according to county units.

## ONE STEP FURTHER

Since the Kansas state hospitals have for some years used the section plan as the basis for their operation, it is this one step further which is proposed as the second phase of the Kansas Plan. Following the lead of the Clarinda group, the present section plan is to be modified by dividing the hospital districts into "county groups." Thus, each section will serve a specific group of counties, and all male and female patients from these counties will be admitted and treated on the same sections. The specialized geriatrics sections will be discontinued, and the older patients will be assigned to the county group of their residence. As with other psychiatric patients, those geriatric patients too ill or infirm to be on a psychiatric ward will be assigned to the medical and surgical unit. Likewise, the outpatient departments will be discontinued and outpatient treatment will be given according to county of residence.

It is believed that this reorganization will lead to much improved communication and better services to patients. A probate judge and other county personnel will be able to work directly with one section and one staff within the hospital. Likewise, each section staff will work with fewer judges, county departments, etc. This should lead to the development of much closer working relationships and understanding between the communities and the hospitals. Another major advantage is that segregation of patients according to age, sex, diagnosis, or behavior patterns will be discontinued. These segregations are based not on patient needs, but rather on staff needs, and lead only to further isolation of the patient and regressed "back wards."

All three of the Kansas state mental hospitals will adopt this plan. It is expected that there will be some variations at each of the three mental hospitals, but the basic concepts will remain quite similar. The plan will not, however, include the Dillon Hospital for the Criminal Insane located at Larned State Hospital, or the Kansas Treatment Center for Children located at Topeka State Hospital, since by statute these units are designated as separate hospitals, under the direction of the respective hospital superintendents, to serve the entire state.

For a number of years, the authors have been concerned about the need for more community psychiatric services, particularly for pre-admission and follow-up of patients needing hospital treatment. By legislative action, the 1957 General Sessions of the Kansas Legislature established a framework which makes it possible for communities to set up mental health clinics with the cooperation of the State Board of Health and the State Board of Social Welfare. Although a few clinics have been established, there is still a great need for more community mental health centers. The dearth is primarily because of the lack of psychiatric personnel to staff clinics. This problem is not unique to Kansas. In describing state and local psychiatric services throughout the United States, Dr. Stevenson[1] says:

"The most serious problem confronting our state hospitals is their isolation. For the sake of their patients they need a close working relation with the health and welfare agencies of their districts, and in turn these agencies need the help of the hospitals. But the isolated hospital tends to limit its attention to the patient to the period between his entering and leaving. It does not, unfortunately, provide enough social service to bring it into closer relation to the communities in its district. Nevertheless, the best professional work demands close relations with communities from which a hospital's patients come. This is different from the public relations with the community in which the hospital is located. The public relations of many hospitals may be excellent for their immediate environs, but these may have little bearing on the services to specific patients, particularly those who live at a distance. Isolation also limits the community's knowledge of the hospital and its needs, and as a result the citizens in those communities do not take the responsibility for supporting adequate provision for the hospital.

"The isolated hospital does not concern itself with the prospective patient who might be given early and effective treatment in his community. More often than not, it even terminates its psychiatric service when the patient leaves it, so that he returns home without the help of those who know him best. It is for this reason that the

[1]*Stevenson, George S.: Mental Health Planning for Social Action. New York, McGraw-Hill Book Company, Inc., 1956.*

establishment of clinics under the same authority as conducts a hospital is an important step. It insures a broader service to patients and breaks down the hospital's isolation. . . ."

Despite the real need for more community services, Kansas has been most fortunate in having the active support of its citizens for measures to improve the care and treatment of the mentally ill. Kansas is fortunate in another respect: that the administrative structure of the State Department of Social Welfare permits a close working relationship between the state hospitals and the county departments of social welfare. Their cooperative efforts have facilitated the admission of patients to the hospitals and the discharge of patients to their communities.[1]

Consideration of the community needs and the existing framework of community agencies has led to the development of the third or Community Phase of the Kansas Plan. This consists essentially in the establishment of four clinics in each hospital (one for each section or county group) in the four principal or most centrally located cities or towns of the hospital's district. Hopefully these clinics will be established in existing welfare department offices of the counties most able to develop the services. It is expected that these clinics will require only two full-time employees—a social worker and a secretary. The remaining staff—psychiatrist, psychologist, and other hospital personnel as may be needed—will come from the hospital section serving the county and will work at the clinic for at least one full day a week. Thus patients will be treated by the same staff before hospitalization, during the period of hospital care, and following their discharge.

## IMPLEMENTATION OF THE KANSAS PLAN

To date, this reorganization is in the beginning stage. It is expected that after orientation of hospital personnel, the implementation of the Hospital Phase will proceed in the following order:

(1) Determination of the number of patients currently hospitalized, by county of residence.

(2) Determination of the average number of admissions a year from each county.

(3) Assignment of specific counties to the four sections of each state hospital. (It is important that adequate discussion with county welfare departments, probate judges, etc., be conducted to thoroughly acquaint all concerned with the process taking place and to gain their support. Since each hospital district includes one large city, it is possible that one entire section of each hospital will be needed to serve the county where the urban center is located.)

(4) Movement of all patients in the hospital to the appropriate section, according to their county group.

(5) Discontinuation of outpatient departments as separate units. Their personnel will be assigned to sections. Each physician will see his outpatients in his section office. The same applies to other professional disciplines.

(6) Assignment of all clinical personnel, with the exception of the clinical director, to sections. Department heads of psychology, social service, nursing, and adjunctive therapy will retain their administrative functions, along with their new section responsibilities.

The reorganization of the hospital itself can be done in a relatively short time, providing all staff members are thoroughly acquainted with and are supporting the change. The hospital staff and county personnel will have to develop a body of experience operating on the county-group basis or Hospital Phase before we proceed to the Community Phase, the implementation of which should proceed as a gradual transition and normal growth.

As each hospital section develops adequate experience operating on the county-group basis, it is expected that we will implement the Community Phase in the following order:

(1) Determination, with the personnel from the counties served, of the most appropriate location in which to establish a clinic.

(2) Determination of the functions of the clinic. At this time, it is believed that the clinic could serve in the following ways: a) interviewing and evaluating all individuals (except emergency admissions) from the counties served who may need psychiatric hospitalization; b) providing supportive psychiatric services to those individuals who may need treatment other than hospitalization; c) supporting, working with, and following-up those individuals who have been discharged from the hospital; d) counseling and advising community agencies on problems relating to mental illness; e) assisting with educational activities within the community in relation to mental health, insofar as time and available staff will permit.

(3) Planning for and obtaining the services of a

[1] *Long, Frank, and Jackson, George W.: Integration of Services in Kansas, Pub. Welf. 15: 61-66, 75-76 (April) 1957.*

## Psychiatrist to Join Mental Hospital Services

The Medical Director is happy to announce the appointment of Donald W. Hammersley, M.D., as Chief, Professional Service, of the A.P.A. Mental Hospital Services. Dr. Hammersley is presently Director of Professional Education and of Professional Services at the VA Hospital, Topeka, and a Faculty Member of the Menninger School of Psychiatry. Dr. Hammersley will assume his new position in June, 1961, and will be the first full-time psychiatrist to be responsible for all professional aspects of the Mental Hospital Services. He has been a fellow of the A.P.A. since 1951.

full-time social worker and a secretary, and determining their functions. It is believed that the full-time social worker should coordinate the activities of the clinic, as well as participate as a member of the psychiatric team. In addition she should function as the chief liaison officer between the county group and the corresponding section of the hospital. She would also participate in and expedite emergency admissions arising in her county group, by obtaining information, and passing it on for prompt action.

To summarize this phase, these clinics will be used to screen prospective admissions and give follow-up treatment to discharged patients. Later they should be able to provide other psychiatric services for the community (as outlined above). Hopefully, these will cover the areas of education and consultation with other community groups on activities and projects which would promote the mental health of the citizens in the area served by the clinic.

In summary, the Kansas Plan proposes reorganization of the hospital sections according to county groups, and extension of the hospital services to the community through the development of clinics.

Some of the expected outcomes of adoption of this plan are:

(1) More effective and economical treatment of patients who require hospitalization.

(2) Further reduction of the average daily patient census in the hospital.

(3) Provision of more psychiatric services to the community.

(4) Maintenance of discharged patients as responsible members of the community to the limit of their capabilities.

(5) Enhancement of educational opportunities for students who receive part of their psychiatric preparation in the state hospitals.

The Kansas Plan should be a major step in further integrating the mental hospital as a part of the community and its services. This will be particularly significant for those areas of the state where there is a scarcity of psychiatric facilities and services. •

# *Have You Read?*

IMPROVING NURSE-PATIENT COMMUNICATION, by Stanley H. Eldred, M.D., in the November issue of *The American Journal of Nursing*. "Words are but a part of the process of communication. We must also be aware of what our gestures, inflections, and movements say to patients," says the subtitle to the paper.

Dr. Eldred's article brings to mind the old saying "It's not what you say but how you say it that's important." "The nurse who is aware that the mentally ill patient is apt to use intonation patterns in the wrong place is better able to understand what the patient says with his words, and she is also able to be more aware of his feelings. She doesn't expect conformity to the cultural norm. She listens for cues and partial, parenthetical bits of communication." We read further, "Most of us, by the time we have reached maturity, have been taught to be aware of what we say in words. We are careful in our professional roles not to say the wrong things. We are unfortunately not so aware of what we communicate with the other modalities—our tone of voice and our kinesics [a coined word to include body set, rhythm, and non-rhythmical movement as well as actual gestures]. For example, a nurse who had a heated argument with her husband on the way to work would not think of continuing her complaints to her patient. But unless she has an unusual capacity for self-observation, she is very likely to continue to communicate her anger through her tone of voice and her kinesics in her first contacts with patients. Most of us are equipped to make allowances for this sort of thing and not take it personally. A psychiatric patient is less well-equipped and is apt to wonder what he did to elicit her angry tone of voice."

Another type of communication is described in ADMINISTRATION COMMUNICATES WITH THE MEDICAL STAFF by Robert S. Myers, M.D. (*Hospital Progress*, November, 1960.) Because the two parties involved have a common goal—the care of patients—but speak a different language, it is of prime importance to establish a good two-way system of communication in order to achieve this goal. The author lays down a few simple rules, and elaborates some of the points that will help create such a system. "There is nothing mysterious or profound about communication, nor is there any magic formula which guarantees its effectiveness. It is simply a matter of common sense, of courtesy and of eternal vigilance—which is always the price of success."

UNIVERSITY PROGRAMS IN THE FIELD OF AGING, by Helen S. Wilson, in the September issue of *Geriatrics*. This paper reports the programs of education in the field of aging provided or sponsored by American colleges and universities. Also enumerated are some of the trends and developments in educational services for the aging in many sections of the country as well as some of the needs yet to be fulfilled.

SMALL CHANGES BRING BIG SAVINGS IN SUPPLIES, by Lucille N. Hall, in *The Modern Hospital* (November 1, 1960) reports on a part of the research program conducted by the housekeeping department of the VA Hospital, Hines, Ill. The author discusses lowered operating costs through better handling of supplies.

# ANNOUNCING

## THE 1961 MENTAL HOSPITAL SERVICES ACHIEVEMENT AWARDS CONTEST

DURING THE PAST YEAR, Harold R. Martin, M.D., Rochester, Minn., Chairman of the Achievement Awards Committee for 1961, has been working with his committee members to redraft the rules of the contest, in order to make it more meaningful. Dr. Martin's group is a subcommittee of the A.P.A. Mental Hospital Services Board of Consultants, and in his endeavors he has had the active support and interest of this board. Serving with Dr. Martin on the Awards Committee are Stewart T. Ginsberg, M.D., Ind., and Hayden H. Donahue, M.D., Ark., with Robert S. Garber, M.D., N. J., as consultant.

The Awards Committee will consider any type of program as eligible for recognition. Thus applications may describe a simple but effective method of ward management, an over-all state or hospital reorganization of such scope that it may influence the practice of hospital psychiatry, a better method of caring for elderly chronic patients, a new type of facility or program for children, better management of the mentally retarded, and so on across the broadest possible spectrum. The only criterion the committee will observe is whether the program benefits the individual patient, or makes a significant contribution to the field of psychiatry.

Applications for Achievement Awards are invited from public and private hospitals in the United States and in Canada. State and provincial commissioners are urged to stimulate participation among their hospitals. There will be no classification of awards according to the various types of hospital.

The Honorable Mention Certificates are to be abandoned and instead, three plaques or medallions— gold, silver, and bronze—will be awarded to those programs which, in the opinion of the committee, merit such recognition. A drawing of the new awards, now being designed by an experienced artist, will be published in MENTAL HOSPITALS as soon as approved by the committee.

The closing date for applications is April 1, 1961. As in previous years, four copies of each application should be sent to the A.P.A. Central Office in Washington, D. C. Applications must be not more than six pages long, typewritten, and double-spaced on one side of 8½" x 11" paper, but supporting material in the form of additional documents, charts, photographs, or newsclippings may be included. Such supporting material should be pasted or otherwise attached to an 8½" x 11" sheet, and clipped to the back of each copy of the written application. Four copies are needed. Please do not mount photographs, newsclippings, charts, etc., into albums.

All applications and supporting material become the property of the A.P.A., and will not be returned, except by special request after the contest is over. Only three of the four sets of supporting material will be returned on receipt of such requests.

As in previous years, the Achievement Awards will be announced and presented during the annual Mental Hospital Institute. Information about the winning applications will be published in the November 1961 issue of MENTAL HOSPITALS, and in the earliest possible issues of the A.P.A. NEWSLETTER, and THE AMERICAN JOURNAL OF PSYCHIATRY.

The Awards Committee will meet in May 1961 to make tentative selections, and thereafter, the chosen applications will be submitted to the appropriate A.P.A. District Branches for evaluation. Two additional sources will be asked by the committee for further evaluation.

ADDRESS APPLICATIONS TO:

HAROLD R. MARTIN, M.D., CHAIRMAN, ACHIEVEMENT AWARDS COMMITTEE,
THE AMERICAN PSYCHIATRIC ASSOCIATION, 1700 18th St., N.W., WASHINGTON 9, D. C.

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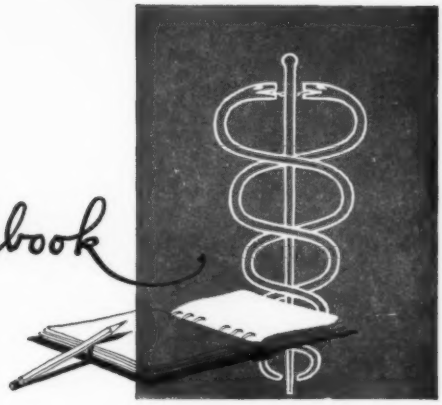
# The Editor's Notebook



I AM INDEBTED to Mike Gorman for calling to my attention a letter he received not long ago from a patient in one of America's oldest and most respected mental hospitals. All of us get many letters from patients, most of which we can only pass over with a sigh and file. But this one is not so easy to file, I think you will agree. Here is how it reads:

"Psychiatry is mediocre or poor because the doctors are overburdened. Rehabilitation and research hardly manage to crawl at snail's pace. Room and board and diversions have improved but the alleviation of human misery, particularly of mind, heart and spirit, shows no appreciable gains. Daily environment and routine after a year causes each day to seem the same, regardless of any diversions. Time seems to stand still, drag interminably, or take flight. Either way, it causes a feeling of irretrievable loss. One realizes he is aging, and the older he becomes while in the institution the more difficult, if not impossible, it will be if he is fortunate enough to obtain release, to secure a livelihood and adjust to the rapidly changing times of a critical era in our country's history. Many patients have to stay in a mental hospital for the remainder of their lives because they are outcasts, rejected, poor, aged, forsaken and forgotten and without any means or kin whatever.

"One sees an elderly patient drop dead upon the floor amid the stench and din of a roach-ridden ward, or die gradually after weeks, months, or years of debilitating ailments, and one can't help asking himself, 'Will that be me?' In the dead or dying patient, he sees himself after the passage of several years or decades.

"In the war against mental illness, it is a grievous disservice to our God, humanity, and our country, to this generation and future generations, to be apathetic and reluctant to make the necessary economic sacrifices in order to provide the funds required to combat and overcome one of the most humiliating and disruptive plagues of all. It will be a shameful blot on the sense, decency, and honor of Federal and state governments and the public if they fail to rouse from their lethargic half-way and wait-and-see attitude.

"Is it a case of too much money? It will be protested that buildings, roads, bridges and other projects are needed now. Are these things more important than human beings? These can wait. The health of the people has precedence, as succeeding generations will testify.

"I am ugly, of meager education, poor voice, no home, wife, or family, rejected by kin, have little money, no livelihood, no freedom and independence, no normal life. I am nothing, except in the eyes of God. I must make do with what I have—an able mind and the knowledge of suffering. What I can do to help others and bring happiness I do, and I consider myself rich.

"I can see that my bleak plight here is rendering my efforts futile. Daily my lot becomes more lonely and desperate. I can only hope my suffering will not be in vain—but will mean courage, solace, help, and hope for others. The bitter cry of anguish you hear is not mine alone, but that of all who are stranded and abandoned."

Now if I read this wonderfully human and articulate patient correctly, including his innuendoes and overtones, he is being as charitable as he possibly can in giving us credit for what we have tried to do for him, and he is telling us, in all humility, that really it hasn't added up to very much in human terms. Room and board have improved, he says, and that's about it. Do you not agree with me that he has defined our job for us in the sixties about as well as any of us could do it?

Matthew Ross, M.D.

*Photo Courtesy Warren State Hospital, Pa.*

By MARY C. MACKIN
*Director of Volunteer Services*
*National Association for Mental Health, New York City*

and LOIS PERRY JONES
*Joint Information Service, A.P.A.-N.A.M.H.*
*Washington, D. C.*

# *YOUTH WANTS TO SERVE*

DIRECTORS OF VOLUNTEER SERVICES in mental hospitals and state schools report that teenagers and college students make excellent volunteers—provided they are carefully recruited, oriented, and supervised.

This judgment was the consensus of the ninety-plus volunteer directors who responded to a query for information about their student programs from the National Association for Mental Health.

The responses indicate that there isn't anything the young people will not try to undertake: a very young girl worked forty hours one week in the library of a school for the retarded; all the boys in a hot-rod club turned out to paint 360 navy surplus beds—again at a school for the retarded; a group of college girls decided all the patients in one women's ward should have their nails painted red, proceeded to paint them, then held a "bop" record hop for the spruced-up patients; two sixteen-year-old girls spent two hours a day during their summer vacation, feeding and lovingly caring for crib cases; fifteen college students, given a choice of wards in which to work, decided the locked wards were for them—"it's more of a challenge," they said.

The youngsters piled into cars and drove 35 miles from their campuses to the nearest state hospital—and rain or shine, came every week over a period of several months. Others came with their parents and worked with crippled children. They came as students of psychology, sociology, "contemporary problems." They came as the junior auxiliaries of adult service groups, as representatives of youth organizations. They worked in the lobby, library, dining rooms, kitchens, sewing rooms, the O.T. department, recreation department, schoolroom, on open and closed wards, on the grounds, and in the community.

Working in groups, they brought with them hula skirts, batons, jazz bands, cookies, favors, books, magazines, games, clothing, candy, sports-equipment.

Most of all, say the volunteer directors, they brought themselves. Here is what some of the directors had to say about their young volunteers:

"Their youthful verve acts as a sort of high-potency vitamin—youth is not wasted on the young."

"Experience here has shown that teenagers and even children not yet in their teens make excellent volunteers and that in many respects they present fewer problems than adult volunteers. They appear to establish rapport with the patients more rapidly than adults. . . ."

"One of the greatest pleasures I have experienced as a volunteer director is sitting back and watching young people handle a ward activity. Most of them approach the venture with fear and trembling but are transformed in one visit. Adult volunteers do not feel as much at ease after months of visits as most young people do after half an hour. Since emotion begets like emotion they draw the patients with them into a milieu of friendship and relaxation. . . ."

"The service these young girls and boys render cannot be measured. Their enthusiasm, willingness, cheerfulness, and dedication have certainly proven contagious.. . . ."

"The teenagers have brought a touch of spontaneity and enthusiasm which has been contagious. Although varied in age from 14 to 18 years, this group has shown surprising insight and a deep sense of responsibility."

"We have developed a philosophy that makes volunteers synonymous with public relations. Young people speak freely of their 'wonderful' experiences while working with the mentally retarded; therefore they are able to bring the school and the community closer together."

In fact, of the more than ninety directors who responded to the request for information, only one sounded a negative note. She stated that, in her area at least, college students seemed to either need or demand money in return for their services. Her experience is quite different from that of directors in other hospitals, one of whom reported that over 150 college students worked without pay in her hospital during the year.

## LIMITATIONS OF YOUTH

Most volunteer directors, however, did specifically mention ways in which the youth and immaturity of student volunteers affected their service. A number of states, for example, have legal prohibitions against employing persons under eighteen in state hospitals; volunteer directors therefore limit their student participation to the over-eighteen group.

A number of other volunteer directors mentioned that students under a specific age—usually sixteen or eighteen—were prohibited from working directly with patients. Thus a young lady of sixteen might work on the information desk in the lobby, but would not be permitted to write letters for the patients, or take walks with them. Age restrictions were more important in mental hospitals than in state schools for the retarded. Appar-

ently it was considered that even fairly young students (twelve or thirteen) could work effectively and safely with young retarded children. One director, for example, commented on the wonderful service given by a group of 12- and 13-year-old Girl Scouts to a cottage of 12- and 13-year-old retarded girls.

## PROBLEMS WITH YOUNG VOLUNTEERS

In addition to the actual age barriers, there were barriers created by immaturity. Most volunteer directors found that the young people needed more supervision and more interpretation of their work than did adult volunteers. A number commented on the fact that the effectiveness of teenage volunteers within their hospitals was limited only by the lack of hospital staff available to supervise the young people's efforts. One director pointed out that young people were not available during the hospital's day shift, when the wards were most fully staffed. Some new volunteer directors were cautious about starting youth volunteer programs until the hospital had had more experience with adult programs.

Furthermore, the hospital administrative staffs feel a great sense of responsibility towards the young volunteer. A number of directors mentioned that they explained the program to the volunteers' parents, and at least one stated that each teenage volunteer had to get specific parental permission to work in the hospital program. Since a major portion of the teenage volunteers were recruited and partially supervised by community youth agencies such as the Y-Teens, the Girl Scouts, and the Junior Red Cross, many volunteer directors left the matter of getting parental permission and support for group activities to the sponsoring group.

Problems of recruitment, orientation, and supervision varied a good bit according to the age of the volunteers involved, whether they were engaged in a group or solo activity, and whether they came into the hospital for a "one-shot" performance or gave regularly of their time on a continuing basis.

As Miss Betty Keenan, director of volunteer services at the Morningside Hospital in Oregon put it: "The junior-high, senior-high, and college-age volunteers should be considered separately, for there is a big difference in the kind of orientation and responsibility you can give them. The younger ones (junior-high age and the less mature senior-high students) are confined to our children's areas, whereas the older ones are treated pretty much the same as adult volunteers. As you can see, the high-school group is the trickiest to deal with and the hardest to generalize about, since emotional maturity differs greatly with the individual."

The range of ages and interests among student volunteers is well illustrated by the partial list of sponsoring groups that follows: Brownies, Cub Scouts, Blue Birds, Girl Scouts, Camp Fire Girls, Boy Scouts, Senior Girl Scouts, Senior Boy Scouts, 4-H Clubs, Future Farmers of America, Future Homemakers of America, Future Teachers of America, Future Nurses of America, Junior Y-Teens, Y-Teens, YMCA, YWCA, Junior Red Cross, Hospital Auxiliary Volunteer Service, American Women's Volunteer Service, Junior American Legion Auxiliary, Spades (Kiwanis-sponsored), Methodist Youth Fellowships, Christian Youth Fellowship, B'Nai B'rith, Catholic High School Girls Sodality Club, Luther Leagues, American Friends Service Committee, high school service organizations, college service organizations, subdeb clubs, college social fraternities and sororities, college departments of psychology, sociology, etc. Of major importance to the volunteer programs of hospitals are the state and local affiliates of the National Association for Mental Health.

The impression one receives from looking over the information sent in by the volunteer directors is that there is scarcely a national voluntary youth agency which has not had some of its young people working in a mental hospital or a school for the retarded. In this, these young people reflect to an astonishing degree the concerns of their elders.

Representatives of the organizations listed above—and other groups—are recruited for work in the hospitals and state schools in a variety of ways. In many instances, the student volunteer program is a natural outgrowth of the adult volunteer program. Adult volunteers, with the needs of the hospital in mind, just happen to think of contributions their children or their friends' children could make. Sometimes the hospital will have as the sponsoring group for its volunteer activities a volunteer activities committee composed of hospital representatives and representatives of civic organizations and interested persons. This group, in touch with the service resources of the community, helps to match hospital and school needs to volunteers and volunteer groups. While some hospitals have occasionally used newspapers, radio, and television to recruit volunteers, most volunteer directors feel there is no effective substitute for the word-of-mouth advertising campaign conducted by the volunteers themselves.

## SPECIAL ORIENTATION PRACTICES

After a youth group has indicated its interest in contributing to the hospital, there is generally a brief period of testing and exploration during which the hospital spells out its aims, needs, and problems more specifically, and the group tests the sincerity of its interests when measured against the realities of the service to be performed. The director of volunteer activities at Brainerd State School and Hospital in Minnesota explains the process in this fashion:

"Usually, when we are aware that a group of youngsters is interested in volunteer work, someone from the staff attends a meeting of the group to explain mental deficiency, describe the kinds of people who are patients, and show slides of the institution. Once a group decides to come to the hospital regularly, we hold three orientation sessions before we accept them as regular volunteers. I cannot stress too much the importance of thorough orientation about the patients and their condition."

The initial contacts of a volunteer group with Central Islip State Hospital in New York are managed a little differently. As the volunteer director puts it: "We encourage committees from these [interested] groups to

visit the hospital where we explain what the total volunteer program is and where they can fit in. We also show them some of the hospital—recreation facilities, sales shop for occupational therapy. . . . After our initial contact we continue our contacts each spring and fall, by mail to all types of organizations to remind them that in the spring we would appreciate being considered for their next year's program; and right after Labor Day we remind them that our volunteer-needs are still gigantic."

Formal orientation programs beyond the lecture-slides and lecture-tour type described above vary greatly. A number of hospitals give college-age students courses similar to those given to Gray Ladies and Gray Men. This type of orientation tends to discourage students only casually interested in the work.

In most hospitals, however, the formal orientation program is brief—between six and ten hours long. Persons listed as participating in these programs included the volunteer director, the clinical director, the supervisor of nurses, heads of the departments of psychology, recreational therapy, or occupational therapy. Assignments to individuals come after department heads have made their needs known, and the talents and interests of the new volunteers have been explored.

One director says: "All new volunteers are given applications and are then placed according to their talents, working with an experienced volunteer. Close personal supervision is given by the [volunteer] director and her assistant, and all volunteers are visited at least once each time they are on the grounds. Although this makes a great deal of extra work and 'tripping,' we feel it has paid off handsomely."

Behind all the different ways hospitals train their volunteers, both young and old, there does seem to be a consensus regarding the basic purposes of orientation, and the general regulations found suitable for most volunteers.

## —BUT BASIC PURPOSES SIMILAR

As stated by the director of volunteers at Colorado State School, the basic purposes of orientation are:

1. To familiarize the group or individual with all or most types of mental retardation (or mental illness) found within the institution, not only from a clinical point of view but also from the viewpoint of the patients' daily habits and needs;

2. To assist the volunteer in becoming acquainted with the physical layout of the institution, with its staff and major departments, and with their individual and combined functions;

3. To consider the volunteer individually and collectively, and to determine where he will best fit into the volunteer program.

General regulations found suitable for most volunteers are: 1) volunteers should be selected following individual interviews; 2) all volunteers are expected to participate in the training program; 3) in general, volunteers under 16 years of age are not permitted to work with adult mental patients; 4) volunteers who contract for regular service are expected to attend regularly.

Following their orientation, in what types of activities did the student volunteers assist?

At the junior-high-school level, the youthful volunteers worked principally outside the hospital. These were the busy Boy and Girl Scouts who collected magazines, made favors, participated in Christmas and other holiday celebrations, etc. A few volunteer directors described isolated instances where rather young volunteers worked closely with young retarded patients.

Activities of senior-high students were more complex and involved more patient contact. One particularly talented group of girls was trained, at the request of the psychology department of a school for retarded, to score tests. Having completed this chore, they moved on to cataloguing the record library for the recreation department of the school.

At Hollidaysburg, Pennsylvania, groups of teenagers, working with the American Women's Volunteer Services, arranged monthly parties with teenagers in the hospital. In Delaware, several teenage girls came with their parents to assist in the crippled children's unit of the Governor Bacon Health Center. Another group of high-school girls, carefully selected, trained, and with full parental support, acted as "big sisters" to individual patients in a state home and training school. In Butner, North Carolina, high school students helped run a Vacation Bible School for the youngsters at Murdoch School.

The activities of college students range from very simple ward visiting activities to the very carefully structured "companion" program carried out at Connecticut State Hospital by students of Wesleyan College. Not infrequently, service in a mental hospital or school is part of the undergraduate student's field experience, carried out in connection with his work in psychology, sociology, recreation, education, or as a premedical student.

Sometimes the groups of college students working weekly in a hospital are large: Metropolitan State Hospital in Massachusetts had 150 who came each week to work in the Gaebler Children's Unit. At Belchertown State Hospital in Massachusetts, 184 college students regularly volunteer. Rochester State Hospital in Minnesota draws volunteers from eleven different colleges.

What are some of the specific activities carried out by college students?

Thirty-five students, working in groups of six, worked in ward activities in four different buildings at Faribault School in Minnesota. . . . In Massachusetts, a group of college students taught a group of retarded boys how to shop, how to tell time, how to manage money. . . . Another group, in the same state school, spent two hours each day "loving" the crib cases. . . . A sorority "adopted" two wards of geriatric patients and visited them weekly. . . . An especially qualified male student undertook to be a regular Sunday ward visitor to the male patients who never had visitors. . . . A music student provided vocal and choral sessions three times a week. . . . Students from a teacher's college gave lessons in a near-by state hospital which had no school for its young patients . . . subjects requested by the patients ranged from remedial reading to college biology, advanced French, and mathematics. . . .

In Rhode Island, three groups of five students each worked weekly in locked wards; they met with staff once a month to discuss problems. . . . At the Mental Health Institute in Independence, Iowa, two students gave ten hours of time weekly as part of their training as recreation workers. . . . In another hospital, one young lady, working with two aides, helped carry out a remotivation program with regressed patients; the hospital staff hoped that eventually six college students would be trained in this work. In the same hospital, students working under the supervision of the psychiatric social workers counseled specific teenage patients.

## SPECIAL STUDENT PROGRAMS

In general, college students gave their special skills to help carry out continuing, regularly scheduled activities. They worked in the clothing departments, acted as receptionists, clerks, librarians, occupational therapy assistants, recreational therapy assistants, music instructors, painters, carpenters, waitresses, cosmetologists, letter writers, companions, entertainers, assistants to chaplains, nurses' aides, etc.

Some special mention should be made of the American Friends Service Committee projects. Strictly speaking, the AFSC project carried out last summer at Central State Hospital, Kentucky, cannot be termed "volunteer" activity, since the students involved received board, room, and insurance, plus a $50 allowance for personal expenses during the summer. It was "volunteer," however, in that students chose to work in a mental hospital for just their expenses when they could have made a great deal more money in a regular summer job.

Each student in the project worked eleven weeks in the newly established rehabilitation unit of the hospital, as a close companion to one or two patients who might later be transferred to a half-way house. A typical day in a student's life could include going to the patient's work assignment in the bakery and working along with him; taking a coffee break; accompanying the patient to a hall committee meeting on which the patient served; going to town in the afternoon to be with the patient while he was interviewed for a job. The two might attend a social activity at the hospital in the evening. All students worked their forty hours using their judgment about when and where they best fitted. Some twelve-hour stints were not unusual, but the students in small groups planned plenty of recreation for themselves after working hours and on weekends. All of the students, according to the director of volunteers, were most reluctant to leave at the end of the summer. They felt the fruits of their efforts were just beginning to show.

Like adult volunteers, student volunteers seem to feel service in a mental hospital or school for the retarded is its own reward. While many directors of volunteers reported that young volunteers were honored with their elders at "recognition teas" or were given service pins after a certain number of service hours, almost all emphasized that youngsters demanded and received no extra recognition for their efforts.

Many directors stressed the program's educational value. Of thirteen girls who served in one hospital, for example, three found their future professional interest in the hospital: one as an occupational therapist, one as a nurse, one as a teacher of exceptional children.

In the words of one student: "We learned that the mentally ill can be made well, but along with this fact we discovered the disgraceful inadequacies of our public mental health program. The handicaps under which the state hospital staff must work became real to us as we met the same problems of inadequate resources and shortage of staff. Most important, we learned to know the patients themselves. We discovered that the mental patient is not a creature to be feared, but rather a person much like you or I."

Of equal import, perhaps, is the unchronicled experience of some college student, somewhere, who found that, contrary to his expectations, working with the mentally ill was not for him.

What did the patients gain from the interest of their young friends? One volunteer director gave an example of their enriched experience in this way:

"Patients enjoy the students and watch for them on the day they are due. When they arrive, the patients have a big smile for them, and even the very withdrawn come forward to greet them." •

## Car Wash Big Splash !

*In order to raise funds to finance the activities of their Teen Club, thirty young patients at Fergus Falls State Hospital, Minn., set up a car wash on the hospital grounds. About forty staff cars were handled at a nominal fee of 50¢ for each car, during the two-day fund-raising exercise. The money collected will be used for off-the-grounds trips, such as visits to the pizza house or to the roller-skating rink.*

# *CONTEMPORARY COMMENT*

## The A. M. A. Joins Battle

E. VINCENT ASKEY, M.D.
*President, American Medical Association*

IN THE WAR WE FIGHT together against the shadowy enemy of mental illness, be assured that the nation's physicians are enlisted for the duration. . . . And when I say "physicians," I am talking about *all* physicians, from the general practitioner to the specialist in every field.

I speak not as a psychiatrist, but as a surgeon who has recognized the tremendous importance of psychiatry in the handling of the surgical patient.

Long before Sigmund Freud was born—in fact, beginning with Asclepias—the physician recognized the effect of mind on body. He was taught that medicine was art as well as science. He learned to allay anxiety, to instill confidence in recovery, to reassure, to comfort. This was essential to his success in healing, for his scientific knowledge was pitifully limited until comparatively recent years.

His most reliable drug was himself, and he prescribed himself more frequently and more successfully than any other drug in the pharmacopeia. Thereby he relieved suffering, and frequently achieved remarkable results. He was, if you like, a sort of pre-psychiatrist without portfolio.

Today's physician is a far cry from the family practitioner of the last century. Increasingly, he tends to specialize—in obstetrics, ophthalmology, gynecology, internal medicine, surgery, psychiatry, and a dozen other fields. Specialization has become inevitable. The proliferation of scientific knowledge required it, and it has helped medicine to keep pace—to the nation's vast benefit.

And so the pendulum has swung—from medicine, predominantly an art, to medicine, predominantly a science. No one can deny that this is good. But it does not mean that the physician can, or should, or will abandon the art of medicine through his preoccupation with its science. The science without the art is barren.

Physicians realize this. They also realize that the difference between the art of medicine, as they traditionally practiced it, and the employment of modern psychiatric principles and knowledge in the treatment of the total patient, is not such a great difference after all. It is a difference largely of degree—an understanding that the ability to heal is enhanced by an understanding of other factors: psychological, emotional, environmental, sociological. A thorough knowledge of the physical, the biochemical, is important. But the physician reaches his full potential only when he achieves a synthesis between art and science.

In recent years, we have developed shining new scientific tools. But we have also reinforced the art of medicine with the tools of psychiatric knowledge. It is cause for rejoicing that these are being integrated into the over-all practice of medicine.

The single fact that we are using psychiatric knowledge with increasing skill marks a giant stride forward in the war against mental illness.

The general practitioner or the specialist in some field other than psychiatry often has a greater opportunity to help his patients maintain their mental health than does the psychiatrist himself. He must seize that opportunity and use it to its fullest.

He can do so only if he is armed with an adequate body of psychiatric knowledge and the disposition to use it. Given these, he can be astonishingly effective in early diagnosis of mental illness, and in the treatment of some forms of mental disease. He can be invaluable in his ability to provide appropriate referral to the proper professional person or agency. This includes referral to the psychiatrist, and to those who work with him as part of the mental health team—the psychologist, the nurse, the social worker, the occupational therapist.

Now I am not suggesting that the larger part of psychiatry can be turned over to the general practitioner or that it should be. I am saying that every doctor can, and must, become an effective practitioner of total medicine—medicine across-the-board. For the physician who practices total medicine contributes massively to preventive measures, helps make treatment available more quickly, helps establish mental health more solidly as a concept vital to every community.

One thing is certain: The psychiatrist alone cannot do the job that needs to be done. He is spread too thin as it is. He needs the help and cooperation of doctors in every type of practice.

To a great extent, he is getting it.

The American Medical Association believes this is as it should be, and is bending its efforts to increase the psychiatric orientation of all physicians, regardless of their speciality. For who is in a better position to deal

*This article is based upon an address to the 10th Annual Meeting of the National Association for Mental Health, November, 1960, Denver, Colorado.*

with mental health and potential mental illness than the doctor who has maintained a close relationship with his patients over a long period of time?

Dr. David Allman, a past-president of the A.M.A., defined the physician's responsibilities in regard to mental illness, when he said:

"First, a physician must know his patients.

"Second, a physician must recognize and accept the value of psychiatric technique in dealing with all his patients.

"Third, a physician must be acquainted with all the community services and resources available in treating and rehabilitating the mentally ill.

"Fourth, a physician should integrate the whole treatment and rehabilitation process. He can help the patient's family understand the nature of the illness and show them how they can best help the patient during his treatment. He can act as a mediator when the patient is released and must be rehabilitated.

"Fifth, a physician has a tremendous educational job to do, not only with patients and patients' families but with the general public in regard to mental illness and mental health."

I am convinced that the nation's doctors agree wholeheartedly with this five-point list of responsibilities, and that we are steadily tightening the bonds between psychiatry and the rest of medicine.

But in all candor, I believe we must redouble our efforts. We must apply our effective knowledge of mental disease to a much greater extent than we are doing at present. Physicians are busy people. Few of them know the luxury of the forty-hour week, and the vast majority work sixty hours or more. They must constantly fight to reduce the gap between new knowledge and its application, and they are hard-pressed to fulfill their other roles as citizens, husbands or wives, and active members of the community. Yet it is heartening to see the interest they display in postgraduate training courses in psychiatric subjects.

I have no doubt this interest will increase as time goes on, for it is estimated that roughly a third of the general practitioner's patients are suffering from primary psychogenic disorders. And what the doctor does with mild psychiatric problems in their early stages can substantially affect future admission rates to our mental hospitals.

I believe it is highly possible that some day certain types of psychiatric illness will be handled by the family doctor instead of the psychiatrist: among these may be many of the psychosomatic conditions, many early anxiety states, the follow-up of some schizophrenic conditions, and perhaps some of the depressions.

I believe the effectiveness of the new psychotropic drugs can help make this prediction come true, and that an entirely new approach to mental illness in the community will develop within our next decade of progress.

Essentially, I think we shall see the dispersion of psychiatry into the community—which is where it belongs. We shall see open hospitals, day and night hospitals, sheltered workshops, aftercare programs, outpatient departments, clinics, half-way houses, and community mental health centers replace the large hospitals as treatment centers. And we shall see our public mental institutions integrated more closely into a network of community facilities.

The nation's physicians cannot do the job alone. Every human being has a stake in this battle, be he clergyman, teacher, social worker, policeman, judge, civic worker, or just plain citizen. The progress of the National Association for Mental Health attests to the truth of this statement. The job is to educate 180 million Americans as to an acceptance of that fact, for until we do, our efforts to treat, prevent, cure, and rehabilitate the mentally ill will be only partially successful.

The physician's role in the over-all effort must be, as in all matters affecting health, a role of leadership. He must be his community's leader, voice, and conscience.

As I said in my inaugural address, when I assumed the presidency of the American Medical Association:

"Whether the problem involves the understaffing of a county hospital, the need for modernizing a mental institution, or the improvement of a school health program, the physician must assume the responsibility which is uniquely his."

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# Psychiatry Secures A Beachhead

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WE HAVE as a society, been advised by one of our leading contemporary historians that the twentieth century will be remembered not for its political crises or technical inventions, but rather as a period in which man actually began to take an interest in the problems and needs of his fellow-men. There are few areas of endeavor in which this statement may become more true than in the area of the care and treatment of the mentally ill. At long last man is beginning, actually, to accept mental illnesses as a truly medical and social problem and has, on a more or less world-wide basis, begun to develop active humanitarian programs directed toward controlling this devastating force. . . . Those of us who have worked to bring better care and treatment to the mentally ill feel that at last we have secured a beachhead—small though it may be—and that we can now begin to mount an all-out attack against mental illness as an overall problem. . . .

# What Do Families Ask?

By BERT KRUGER SMITH
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THE MENTAL PATIENT AND HIS FAMILY are currently regarded as an indivisible unit. Close relatives are accepted as vital members of the treatment team, and their services are frequently enlisted both during and after hospitalization. It is well recognized that mental illness is not an isolated phenomenon striking just one person but is more like a word shouted into a canyon, reverberating and echoing back and forth against the walls and crevices.

Since the relationship of the mentally ill person with his relatives is indissoluble, the strength and knowledge of the relative become a therapeutic force in the patient's recovery. To present factual information about mental illness and about a particular patient often takes more time than the understaffed social service departments can manage. This fact raises these questions: Can printed materials help to give information about mental illness? Will relatives of mental patients accept such information freely? Will they take initiative in obtaining factual booklets?

These questions formed the basis for a small study undertaken in 1958 in Austin, Texas. Three agencies, The Texas Association for Mental Health, the Board for Texas State Hospitals and Special Schools, and the Hogg Foundation for Mental Health cooperated in the endeavor. The booklet selected for the study was *Mental Illness: A Guide for the Family* by Edith M. Stern. Although published originally by the Commonwealth Fund, this booklet was reissued by the National Association for Mental Health. It is written directly to the relative, is 95 pages long, and contains no inside art work. It takes up such pertinent questions as how to go about hospitalizing a patient, how the relative can help while the patient is hospitalized, and what he can do to speed rehabilitation after the patient is discharged.

The Texas study was geared primarily to assessing two different methods of distributing mental health materials, and secondarily to gauging, as far as possible, the amount of the booklet read and its effectiveness in increasing knowledge about the subject.

Rusk and Wichita Falls State Hospitals were chosen as sites for the project because they are comparable in size and have approximately the same number of admissions per month. Types of admissions are likely to differ, however, since Rusk is in East Texas, close to the Louisiana border, in the heart of the "Piney Woods," and contains a large settlement of Negroes; while Wichita Falls, in the country of flat red lands and deep black oil, draws to it the oil roustabouts and ranchers. Latin-American patients were eliminated from the study because of the language problems. Persons placed in state hospitals because of criminal court commissions were also excluded.

It was decided that the booklet, or information about it, should be made available at the time of the initial social-service interview, which is generally conducted with the relative while the patient is seen by a doctor. Two distribution methods were alternated in the hospitals: for the first four months, a member of the social service department of one hospital handed the booklet to the relative accompanying first-admission patients, while at the second hospital, the social worker gave the relative a form letter and blank card on which the booklet could be requested. At the end of four months, the procedure was reversed in the two hospitals. A month after receiving the booklet, the relative was sent a questionnaire to be filled out and returned to the hospital. Space was left on the questionnaire for comments.

## RESULTS

Eagerness for information was demonstrated by relatives throughout the eight-month period of the project in both hospitals and under both methods of distribution. In Wichita Falls, of the persons who had to send for the booklet, three out of four responded, and in Rusk the number was one out of two. During the period of the study nearly 900 persons were either given or mailed the booklet, and from this number nearly one-third returned the questionnaire. No significant statistical differences were found in the amount of the booklet read by those who received it at the hospital and those who had to send for it. Of those who received the letter, 27.4 per cent, and of those who were handed the booklet, 26.9 per cent read parts or all of the material. It might be concluded that, once motivated to read it, the two groups completed about equal amounts of the booklet.

Questionnaire responses indicated decided interest in the information contained in the booklet. Typical of the responses were these:

> "I don't see how I could stand up under the strain of having to send my son off if it had not been for the little book. I am so grateful for it and thank Heaven every day that it was sent to me."

> "Every one should receive a copy of your book so

they would know how to treat a mental patient after they are well. So many people make an issue of mental sickness because they don't understand it."

"I think an orientation class should be held for the relatives, consisting of the teaching in this book."

"This book has explained so much to me that I wish I had known months ago . . ."

**SIDELIGHTS**

Every study, no matter how modest, brings forth some provocative sidelights which shine through the fabric of the primary idea. In this case the hospital's relation to the family member became a theme which recurred in many returned questionnaires. In almost one out of two returned questionnaires, the family member asked for better communication with the hospital. Some of the comments went like this:

"I was in suspense as to how my loved one was progressing. I feel that if the hospital could inform the relative of patients nearing discharge, it would be of some help."

"I know it would be expensive and time-consuming, but I feel sure all relatives would appreciate periodic progress reports on patients."

"You should explain to the nearest relative just how the patient reacts to treatment and what results can be expected."

"Would like a chance to see where and how they sleep."

"Upon committing a patient, I would suggest warmth and care be shown relative of patient who is extremely concerned and in need of being put at ease."

"Upon coming home a small booklet or personal letter from doctor as best attitude towards understanding patient."

Since data in this study showed that 88 of 100 people who bring a patient to the hospital for the first time are in the primary family group, it seems significant that these people be made a part of the treatment team and that their help be enlisted in aiding the mental patient toward recovery.

Further studies might well concern themselves with the hospital's relation to the family member and also of ways of breaking down the isolation in the patient-relative and relative-hospital relationship.

This small study showed that relatives who bring a patient to a mental hospital for the first time are, for the most part, motivated to learn more about mental illness and are eager for further word about their own loved one. More than one in four of these persons either took or sent for *Mental Illness: A Guide for the Family,* read some or all of it, and responded to a questionnaire.

Yet, of all the data tabulated, perhaps the most poignant and the most meaningful for mental hospital personnel was scrawled in the large and almost illegible hand of one relative. In answer to the question: "What other services would you like to have available in the way of service, explanation, or assistance?" she wrote this one word, "Kindness!" •

# Group Therapy For Families

By WILLIAM S. WIEDORN, JR., M.D.

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FAMILIES OF PSYCHIATRIC PATIENTS are blamed for many things in mental hospitals. Lack of progress of the patient, indeed the illness itself in its immediate clinical presentation, may be blamed on the patient's family. Conversely, the significance of the feelings, attitudes, and roles of the family in the remission and subsequent continued recovery of the mentally ill patient has also been frequently documented.

Observations of families during the thrice-weekly visiting days on the LSU Psychotherapy Research Ward suggested that more structured and therapeutically oriented meetings with the relatives would be of value. Not only was there much apparent patient-family interaction, but there was observed interaction between families, and between families and the nursing staff. This interaction consisted of comparing notes of experiences with the patient, reaching out for help, and a variety of therapeutic interaction over and above that structured within the ward itself, which is directed primarily toward the patient and the patient-group.

The setting is the eight-bed psychotherapy ward for schizophrenic Negro women at Charity Hospital in New Orleans. Ages range from adolescence to middle-age. Patients receive individual psychotherapy as well as daily group therapy, but little somatic treatment, since they were selected because such measures were not indicated. All of these patients have previously been severely psychotic, and inpatient treatment has been clearly indicated.

The psychotherapy research ward is used for patient care and for detailed studies of psychologic processes in individual patients and in the patient group. The pur-

pose of these studies is to gather data pertaining to the psychologic aspects of the reintegrating schizophrenic.

Families of the patients meet with the therapist on Saturday morning in the ward dayroom. One or two persons associated with the patient usually attend—the mother or the husband, or, less often, the mother-in-law. Sisters, elder children, or a fiancé may also attend, but only rarely does a father come. After the meeting, relatives visit with the patients.

## PATIENTS MAY ATTEND

Patients may sit in on the meeting with the understanding that they are not to participate. They often stay in the next room and quietly but carefully listen to the discussion. In all cases, the patients see and hear the interaction of their therapist and families.

The group is completely open. New family members begin when a new patient is admitted to the ward; older members drop out when a patient is discharged. Since patient-stay varies between two months and a year, the make-up of the group tends to be fairly stable at any one time.

Much of the immediate pathology within the family in relation to the patient is readily apparent in the family group meeting. For example, there may be gross denial of the existence of the patient's psychosis. The family's distorting of communications, or miscasting of the role of the therapist is often strikingly lucid. Family members may communicate or transfer anxiety to the patient or they may even threaten overt violence. On the other hand, even the most acutely disturbed patients have never exhibited open aggressiveness toward their own or other relatives, even though they have been present at the meeting.

## UNDERSTANDING THE FAMILY

It is important to consider the needs of the family. The eruption of overt psychosis in the patient within the home setting, as well as his subsequent separation from the family result in much anxiety among the relatives. This presents itself as guilt, anger, or contempt for the therapist or ward. It evokes fears of overt psychosis in the relatives themselves, and contributes to hopelessness over the patient's condition. These manifestations of family anxiety extend to the patient, and may even be expressed directly. For example, a mother may say to her daughter, who is acutely psychotic and verbalizing much primitive material, "Stop that, you're making me nervous. Stop that, or I'll leave. Stop that, or the doctor won't take care of you."

The family may also evoke anxiety with attendant anger or feelings of isolation from the staff of the ward —therapists, nurses, and nurse's aides. Thus, both limbs of the psychological world of the patient may be at war with each other, mutually evoking anxiety in each other. They may mutually blame each other for the illness, for the lack of conspicuous progress, with the patient lonely in the middle.

The therapist sees the patient's family members with other patients' relatives, and in relation to the patient himself, who is often present. Thus he obtains a more objective variety of observation than he can during the usual formalized interview with the family for purposes of taking history, making recommendations, and so on. Furthermore, the patient sees the therapist interacting with the family, and this minimizes and opens to reality many of his own feelings about the absolute omnipotence of these relatives, especially his mother.

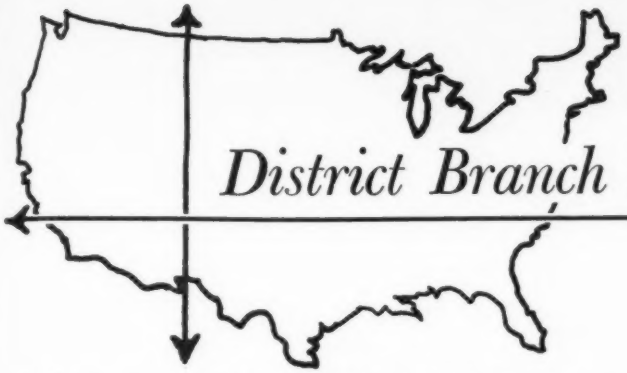
Useful therapeutic interactions also occur between the relatives themselves. The therapist may be able to interpret the guilt or anger of the family, and receive immediate confirmation and corroboration from other relatives. The discrepancy may be pointed out between the family's protestations of concern and love for the patient, and their actual performance in not showing up to take him on pass, not bringing him any clothes or money, or paying him any special attention. The need of the patient for subsequent greater independence upon remission and discharge from the ward may be verbalized, with other relatives or patients agreeing and supporting the patient.

## CASES IN POINT

Clinical examples illustrate the above points. One patient, a single woman in her late thirties, had lived with her mother and sister a life apart from the community, and almost totally devoid of pleasure. There was no self-assertiveness in these three. As the patient reintegrated from a catastrophic schizophrenic disorganization, a catatonic excitement, the sister and mother reported that when the patient was on passes she seemed worse than ever. Soon the other relatives and the therapist discovered that this family reported any participation in pleasure, or any rather conventional aggressiveness as "crazy," and were able to interpret this to the relatives.

The husband, mother, and mother-in-law of a young woman who experienced a slow schizophrenic withdrawal during a pregnancy, with disorganization and almost total regression post-partally, insisted repeatedly that the patient would never get well, and that even if she were discharged she would never be able to assume any responsibilities. When the other relatives and the therapist took a strong hopeful stand about the patient's prognosis and interpreted some of the guilt and anxiety in the family, the massive regression of the patient ceased and she began to show improvement.

Obviously, group therapy with the family members has yielded a number of valuable results. There has been lessened anxiety within the families, and more success in their attempts to re-adapt to the changes in their hospitalized members. Tensions between staff and families are lessened as they are clarified and worked through. More importantly, psychotherapeutic work with individual patients has been facilitated by the interactions and information produced by the family group meetings. At no time during the periods these meetings have been conducted has there been any serious psychotic catastrophe in a family member, though many of them have been quite poorly integrated. It is concluded that family group meetings on the ward are a useful adjunct to psychiatric milieu therapy.



# District Branch News

*As all the members of the Assembly of District Branches are aware, one of my most urgent projects during my year as speaker is to strengthen the liaison between the public mental hospitals and the A.P.A. district branches. The Policy Committee at its meeting in October, 1960, went on record as being in accord with this objective. The speaker-elect, Edward G. Billings, M.D., is in entire agreement. We feel that a step forward has been made in establishing this special page in* MENTAL HOSPITALS, *to be devoted entirely to news of district branch and mental hospital cooperation in programs of all types.*

*Most of this material will be drawn from district branch newsletters, and as more and more such newsletters become established, the flow of important material will increase. If your district branch does not at the present time have a publication of its own, you are urged to send news items directly to Mrs. Lucette G. Nagourny, A.P.A. Mental Hospital Services, 1700 18th Street, N. W., Washington 9, D. C. If you do have a newsletter, will you kindly send a copy regularly to Mrs. Nagourny.*

*The success of this page will depend upon two things: primarily, of course, upon the amount of activity which takes place between the district branches and their local hospitals, private and public; and secondarily, upon the cooperation of all district branch members in informing the editorial staff of* MENTAL HOSPITALS *about such activities. Whether this page is to become a regular feature in each issue of the magazine depends upon these two things. I sincerely solicit your support and cooperation in this new and important endeavor.*

JOHN R. SAUNDERS, M.D.
*Speaker of the Assembly of District Branches*
*Richmond, Virginia*

## BRANCHES TO ASSIST IN AWARDS CONTEST

In May 1958, the Policy Committee urged improved liaison between the A.P.A. Mental Hospital Services and the district branches relative to the Mental Hospital Services Achievement Awards. In May 1960, the committee reiterated this statement, adding that all district branches should take active steps to stimulate the hospitals in their areas to make application for such awards.

Harold R. Martin, M.D., chairman of the Awards Committee for 1961, has taken cognizance of the Policy Committee's action and has written into his rules that each application considered worthy of recognition by the Awards Committee shall be evaluated by a member of the appropriate district branch before any final decision is made. The speaker of the Assembly has requested that each district branch work to encourage each hospital, public and private, in its area to make application for an award. (See also Page 11.)

The Policy Committee approved in principle the request of Alfred H. Stanton, M.D., chairman of the Program Committee for the 13th Mental Hospital Institute, that liaison be established between the appropriate district branch and his committee. Since the 1961 Institute is to be held in Omaha, the Nebraska-North Dakota-South Dakota District Branch is being requested to establish liaison with Dr. Stanton's Committee.

## WESTCHESTER COUNTY SURVEY

The Westchester County (N. Y.) District Branch devoted its October 5 meeting to a panel discussion on "Current Status of Mental Hygiene Programs in the County." The participants were the ten members of the Committee on Community Mental Health Needs (John Briggs, M.D., Chairman), who have been surveying the treatment facilities and their adequacy in meeting the needs of the community during the past year. The committee initiated its survey with particular emphasis on seven points: 1. Treatment facilities for children and adolescents. 2. Optimal use of inpatient and outpatient facilities by referring psychiatrists. 3. Psychiatric and case-work facilities for the Children's Court. 4. Treatment facilities for the alcoholic. 5. Survey of the clinical and financial policies of private psychiatric hospitals in the county. 6. The desirability of a "central" bureau for psychiatric referrals. 7. The need for 24-hour emergency consultation service, to be available to any physician or patient for psychiatric emergencies.

## MASTER PLAN FOR COLORADO

Franklin G. Ebaugh, M.D., president of the Colorado District Branch, has presented a master plan for mental health in the state. Among the points he discussed were the following:

1. Creation of a Governor's Advisory Council to establish administrative policy, treatment procedures, plans for patient movement and management, and residency training programs.
2. Addition to the Pueblo State Hospital of a 250-bed medical-surgical unit, and a 150-bed intensive treatment unit.
3. Future conversion of the Pueblo State Hospital into

an intensive treatment center by, among other things, reduction of patient census and transfer of mild senile cases to nursing homes; and early, individual treatment planning.

4. Organization of a second state hospital on the same level as Pueblo, through the initial use of remodeled barracks at Fort Logan to accommodate 200 patients. Long-range plans call for the evolution of a new 500-bed acute and chronic treatment center.
5. Increased use of private psychiatric hospitals; creation of psychiatric units in private general hospitals; and the future expansion of such private psychiatric facilities and their greater integration into mental health organization.

Bradford Murphey, M.D., chairman of the branch's Professional Standards Committee on Mental Hospitals, moved that a letter of citation be prepared from the membership of the Colorado District Branch to Dr. Ebaugh in recognition of the hours of planning and work that went into the preparation of the master plan. The motion was seconded and passed unanimously by the members.

# *Have You Heard?*

PUBLIC EDUCATION: The State University of Iowa is offering the public a credit course in the education and training of the mentally retarded child. This course, to be held at the *Glenwood State School* (Peter A. Peffer, M.D., Supt.), is intended to awaken community interest in the potentialities of such children, augment community understanding of the problems involved, and ultimately to increase the number of public-school classes for the mentally retarded who are educable and trainable. Proof of public interest lies in the fact that so far forty-one adults have enrolled in the course.

In response to a growing number of requests from school, civic, business, and other local groups, *Hillside Hospital,* Glen Oaks, N. Y., has established a new community education service to provide speakers, films, and other program-planning assistance to Queens and Nassau organizations interested in the hospital and mental health. Mr. Luis E. Bejarano, public relations director at Hillside, has been named to head a committee of staff psychiatrists, nurses, social workers, and counselors to administer the new program, with the full cooperation and participation of local mental health associations.

TRAINING: According to MODERN HOSPITAL (Sept. 1960), "nurses can now become doctors at *Boston University School of Nursing.* This is the first doctorate in the country which specifically identifies nursing in the degree title. The doctor of nursing science degree is offered in psychiatric nursing, with programs in other clinical areas to be instituted in the next two to four years. Previously, the highest level of training offered at the school was the certificate of advanced professional specialization, consisting of a minimum of 30 semester hours of advanced study beyond the master's degree. The new degree program requires 60 semester hours credit in advanced directed study, plus a doctoral dissertation."

RESEARCH: A mysterious error in the life process that juggles the pattern of a human cell and upsets the normal number of chromosomes in the body was blamed at an international meeting in London, England, for certain types of mental retardation. The findings of *Dr. William Court-Brown* of Scotland coincide with those developed in recent California research into causes of mental retardation. In his paper presented at the first international conference on congenital malformations, Dr. Court-Brown theorized that the births of mentally defective children and those with other deformities could be traced to a mistake in nature, occurring when male and female cells combine in the reproductive process. When the error occurs, the resultant cells have either more or less than the normal 48 chromosomes. The psychiatrist discounted the idea that the disorder can be transmitted from parents to children. (The California researchers have advanced the belief that extra chromosomes may be the determinant factor in mongoloidism.)

HISTORICAL: *St. Joseph's Retreat* in Dearborn, Michigan, is this month ending its first hundred years of operation. Founded by the Daughters of Charity under the name of St. Vincent's, it was the first hospital in the Northwest Territory, the first shelter for the insane, the first military hospital and free clinic in Michigan, and among the first in the United States. Known through the years by various names (St. Mary's, Michigan Asylum, Michigan State Retreat for the Insane), the institution adopted its present name—St. Joseph's Retreat—in 1883. Throughout its entire history, the hospital has had only five men responsible for its medical supervision. They were Dr. T. J. Johnson from 1873 to 1908. Dr. Justin E. Emerson from 1908 to 1917, Dr. David R. Clark from 1917 to 1937, Dr. Russell T. Costello from 1937 to 1945, and Dr. M. H. Hoffmann from 1945 to the present.

CONSTRUCTION of the country's first nursing-home research center is on its way in Washington, D.C. The center, scheduled to open by midyear, will be known as the International Nursing Home Education, Research, and Service Center. Built and operated by private funds, it will offer 12-week courses in nursing home administration and patient care; study and publish material on all phases of nursing home activity, including equipment testing, dietetics, and statistics. The center will house a model nursing home, a permanent display of nursing home equipment, research facilities, and the world's most extensive library on the care of the aged.

Number Five in a Series by Past Presidents of A.P.A.

# *TREATING PHYSICAL ILLNESS IN A MENTAL HOSPITAL*

By ARTHUR P. NOYES, M.D. (1954-1955)
*Director, Psychiatric Education*
*State Mental Hospitals*
*Norristown State Hospital, Pennsylvania*

THE STUDY, DIAGNOSIS, AND TREATMENT of physically ill patients in mental hospitals have long been matters of concern and dissatisfaction to the superintendents of such institutions. They usually conceive of the general hospitals as being free from such problems, with an abundance of interns and residents who can readily meet all the needs of the patients and at the same time receive adequate training in the necessary skills. In recent years, however, many general hospitals are experiencing difficulty not only in finding satisfactory physicians as residents, but also in having available a desirable amount of clinical material for teaching purposes. This has been due in part to the expansion of Blue Cross and similar agencies, with a resulting decrease in the number of ward patients desirable for residency training. Perhaps this is particularly true in wealthy communities in which most of the persons seeking hospitalization are private patients.

About ten years ago the Norristown State Hospital constructed a building specifically for its mental patients who are suffering from physical diseases. In order to provide more skillful treatment than had previously been available for such patients, the hospital sought a recriprocal arrangement for an exchange of services with a general hospital. Since Norristown had on its staff both a surgeon and an internist who had passed their American Board examinations in their respective specialities, it seemed logical to make available to the general hospital the rich amount of clinical material in the mental institution for teaching purposes in medicine and surgery, and improve the treatment of the mental patients by utilizing the services of the general hospital residents. It was therefore arranged that residents in training in both medicine and surgery at the Bryn Mawr Hospital, a general hospital located about ten miles from Norristown, should spend a portion of their residencies at the Norristown State Hospital. Accordingly a surgical resident from Bryn Mawr spends one of his four training years at Norristown, and a Bryn Mawr resident in internal medicine spends two and a half months of each year at the mental hospital. This arrangement was found to be agreeable to the respective examining boards in the two specialties. Residents from the general hospital bring new ideas and an educational atmosphere to the medical and surgical department of the mental hospital. In turn they are provided with an opportunity to see a larger number of critically ill patients.

Visiting physicians certified in ophthalmology, urology, orthopedic surgery, neurology, and other major specialties visit the Norristown State Hospital from one to three times per week, providing consultation or treatment for all patients needing the services of the respective specialist.

The care and treatment of chronically infirm patients admittedly does not offer the stimulating challenge presented by the acutely ill. In our experience we have found it more satisfactory to treat the chronically infirm patients in buildings set aside especially for them, rather than in the medical and surgical department. As a result, the patients in the medical and surgical department are more representative of those admitted to a community general hospital, and present similar medical and surgical problems. Patients who are ambulant are brought from the psychiatric wards to the medical and surgical building for follow-up care or for the treatment of minor ills. This gives the resident an opportunity to see patients similar to those he might see in a general outpatient clinic.

As the writer looks back over his incumbency as superintendent of the Norristown State Hospital, he feels that in no other way, perhaps, has he been of greater service to his patients than in the construction of the medical and surgical building and in this mutual arrangement with a general hospital which has been so profitable to both institutions. •

*Avondale Mental Hospital, Auckland*

*Kingseat Mental Hospital, Kingseat*

*Tokanui Mental H*
*tal, Te Awamu*

# The Mental Health Picture in NEW ZEALAND

In the south Pacific Ocean, twelve hundred miles southeast of Australia and half-way between the Equator and the South Pole, lie the islands of New Zealand, a country about the size of the state of Colorado. As of June 30, 1960, the New Zealand population consisted of 2,212,051 Europeans and 159,709 Maoris, the latter being the descendants of the Polynesians who first populated the country. To accommodate the percentage of inhabitants who need psychiatric care, the New Zealand Department of Health operates a network of hospitals and training schools (see map) on the North and South Islands. The way in which these institutions function within the country's total mental health program is described on the following pages. . . . .

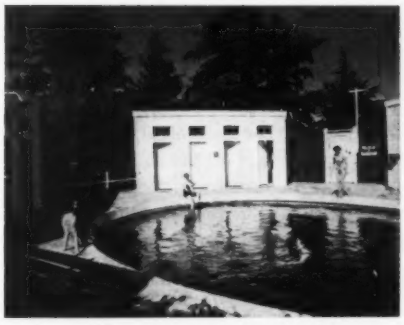
*Templeton Training School, Christchurch*

*Cherry Farm Mental Hospital, Dunedin*

*Lake Alice Mental Hospital, Marton*

*Levin Farm Training School, Levin*

*Porirua Mental Hospital, Wellington*



*Queen Mary Mental Hospital, Hanmer Springs*

*Sunnyside Mental Hospital, Christchurch*

# The Central Plan

S. W. P. MIRAMS
*Deputy Director, Division of Mental Hygiene*

THE ADMINISTRATIVE RESPONSIBILITY for mental hospital services in New Zealand rests with the Division of Mental Hygiene of the Department of Health at Wellington, the capital city. The scope of the division's activities is laid down in the Mental Health Act of 1911 and subsequent amendments. The director of the division reports annually through the Minister of Health to Parliament.

Services for both psychotic and mentally deficient patients are provided by this division, but there are separate institutions for the mentally defective, and the policy is to make separate provision as far as is possible for the two categories. There are at present 10 mental hospitals plus 2 mental deficiency institutions. Planning is under way for a third mental deficiency institution to be located at Mangere on the North Island.

The total number of beds available at present is in the vicinity of 9,600, but this involves a measure of relative overcrowding at some of the older institutions. The present policy is to provide for the accommodation of all patients in 50-bed, self-contained villas, and several of the older hospitals are in the process of being converted to the villa type. In general, it is intended to impose a ceiling of 1,000 beds for mental hospitals and 750 beds for mental deficiency hospitals. At present, three of the mental hospitals are overcrowded to an extent that brings the hospital population above this figure.

Medical services are provided principally on a full-time basis but there are some part-time appointments of psychiatrists to fulfill specific duties. The appointment of general practitioner assistants together with consultants in fields such as neurology and pediatrics has recently been established. The division employs at its hospitals psychologists and social workers, although the numbers of these are below what is considered desirable.

The division also staffs and runs the occupational therapy training school for New Zealand, and there are occupational therapists' positions at all hospitals. Recreation and welfare officers are appointed separately. Chaplains are provided for all hospitals, usually on a part-time basis, by the various churches. Nursing staff, both male and female, is recruited on a professional level. Although there is provision for unqualified assistant nurses, very few are, in fact, so employed.

Individual hospitals are administered by medical superintendents assisted by lay secretaries. There are no hospital management committees. There are, however, formally appointed Official Visitors and Legal Inspectors. In recent years various voluntary organizations have provided valuable assistance in the field of social activities and visiting.

A detailed statistical system has been evolved for collecting information with regard to admission, discharge, and treatment of patients on a national basis.

This scheme was devised in consultation with the province of Ontario, Canada, with broad agreement as to definition, classification, and tabulation in order to provide some basis for statistical comparison between the two services.

The medical staff of the division provides consulting psychiatric services for many outpatient clinics at general hospitals, for courts, prisons, and child-welfare agencies. In addition, the division provides some consultants in child psychiatry to work in child health clinics. The provision of these extramural services is possible only by virtue of the enthusiasm of the division's medical staff, which is at present below the desirable minimum. There are, in fact, shortages of trained staff in all categories, except that of the qualified male attendant. The proportion of qualified and experienced nursing staff on duty daily is, however, above that of many similar services in other parts of the world.

# A Typical Hospital

J. D. HUNTER, *Medical Superintendent*
*Sunnyside Hospital, Christchurch*

AN ENCYCLOPEDIA OF NEW ZEALAND, Canterbury section, published in 1903, tells us that in the early period of the settlement in Canterbury, the mentally sick were accommodated in a portion of the Lyttelton Gaol, under the supervision of the Chief Gaoler, G. E. Seger, afterwards lay-superintendent and still later steward of Sunnyside Asylum. Sunnyside Asylum, as it was called, was situated in a block of land facing the Lincoln Road beyond Addington, about three miles from the city of Christchurch, Canterbury, New Zealand.

In 1868, the patients were transferred from Lyttelton to Sunnyside, and by 1887 the main portion of the present hospital was erected. The women's ward, or west wing, was built first, followed by the men's ward, or east wing. The central administration block was erected in 1887 and

has both a southern and northern aspect. Each wing has four wards.

The hospital is surrounded with fine grounds and beautiful lawns which are kept in splendid order and are very pleasing to the eye. There is also a farm attached, which provides for diversified employment.

The changing views and attitudes toward mental illness have necessitated the modification and adaptation of the buildings to modern treatment and rehabilitation. An admission ward which was built in the 1920's has become out-of-date and is being replaced by a modern new admission ward with up-to-date equipment and facilities. It is intended to be as like a home as possible and to do away with the sense of restriction, using open wards and more freedom to an extent compatible with the condition of the patient and the interest of the general public.

About 1920 the idea of small self-contained villa-like units was introduced in New Zealand. These are of various types, some two-storied, but the general principle is the same. These villas can be used as open units, or closed where necessary. They consist usually of four dormitories of 12 beds each, and there are four single rooms, which are used mainly by those suffering from temporary physical illnesses. Each bed is provided with a bedside locker where the patient may keep his personal treasures and his day-to-day articles. A large locker is provided off the dormitory for more bulky personal belongings. There is a generous, comfortable, airy lounge, suitably and tastefully furnished with floor rugs, small occasional tables, and soft furnishings. Various colored drapes give the general appearance of a hotel lounge rather than a hospital. The dining rooms are situated ad-

**Zeitschrift für Biologie, Band 112, Heft 1**

## Berichtigungen

**Beitrag Vossius:** Die Seiten 40 und 41 wurden durch ein Versehen nach der Korrektur vertauscht. Die Fortsetzung von Seite 39 ist auf Seite 41 zu finden, daran schließt sich Seite 40 an.

**Beitrag Winterstein und Frömter:** Auf Seite 59 oben wurde versehentlich nachträglich die Bildzählung vertauscht. Abb. 1 a muß unter der linken und Abb. 1 b unter der rechten Abbildung stehen.

joining the kitchen, which has the latest equipment for the cooking and serving of the food. The food is served cafeteria-style to patients, who are then seated at small tables accommodating four to six persons. This system ensures that the patients get their meals fresh and hot.

The villas have up-to-date bathrooms and showers which, in the majority of cases, have the hot water thermostatically controlled and suitably mixed so that it is available at any particular specified temperature. The heating of the villas is of various kinds—open fires, steam heaters in the corridors and in some of the sitting-rooms; the bathrooms and dressings rooms are heated by overhead steam heaters.

Each villa is situated in its own grounds, which are laid out in lawns, flower beds, and shrubs. The whole gives a pleasing outlook and a pleasant setting with the impression of openness and space.

There are several villas of this type at Sunnyside, and there are plans for the gradual replacement of the present main hospital block with suitably designed villas. These are being added from time to time so that eventually the old original buildings will disappear.

# The Medical Services

P. P. E. SAVAGE, M.B., Ch.B., D.P.M.
*Deputy Supt., Sunnyside Hospital, Christchurch*

CLINICAL PRACTICE at Sunnyside Hospital derives largely from the orthodox traditions of England and Scotland. Out of the present medical staff of five, four possess the Diploma of Psychological Medicine from British universities or from the British Royal College of Physicians and Surgeons. This qualification is the Commonwealth equivalent of certification by the American Board of Psychiatry and Neurology.

Postgraduate university training is not yet available in New Zealand except to a limited extent in the field of academic psychology. The Division of Mental Hygiene provides bursaries for suitable members of the hospital staff to study overseas.

At present, the medical and psychiatric services of the hospital are provided almost entirely by the full-time members of the medical staff. The medical superintendent's time is occupied to a considerable extent with administrative duties but he also conducts outpatient clinics at local general hospitals in various points throughout the hospital's catchment area. The deputy superintendent has charge of the male wards. The psychiatrist in charge of the female wards shares with the deputy superintendent the services of a junior doctor training in psychiatry. A general practitioner attends daily at the hospital to assist with problems of medical care. Help is also available from the visiting consultants in neurology and medicine.

The hospital employs as part-time house physicians, two medical students in their final year of training. This scheme gives valuable insight into psychiatry to medical students at the undergraduate level. Not only do they gain practical experience under supervision in the minor medical jobs which a big hospital always provides, but also they have unique opportunities for certain basic psychiatric experience, not usually available at the undergraduate level. The posts as student assistants are keenly sought and a number who have held such posts have returned later to the qualified staff.

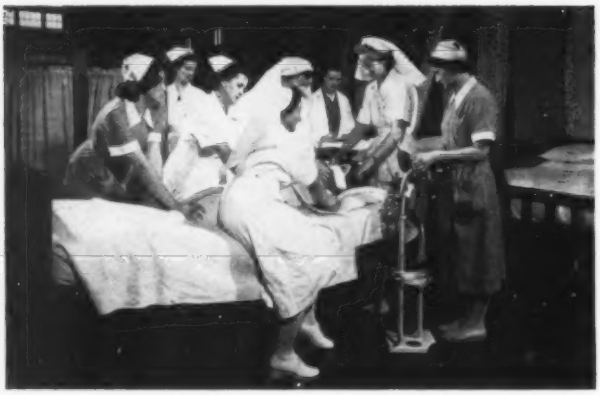
Laboratory facilities are available at two general hospitals in the area, which are both close to Sunnyside. The various specialist outpatient departments of these hospitals also give valuable assistance.

The Christchurch Hospital provides facilities for air encephalography as required. As yet Sunnyside has no EEG facilities, although an electroencephalograph machine is on order. At present, patients have to be sent some 200 miles to the medical school for electroencephalography.

The hospital psychologist, working under medical direction, provides intelligence- and personality-testing of both general and specific types. In addition, he assists in research projects carried out by the medical staff and also conducts certain delegated psychotherapeutic tasks.

Patients admitted to the hospital, unless extremely disturbed or demented, are accommodated first in a 20-bed admission ward with adjacent dayroom facilities and a toilet block, the whole unit being under immediate nursing supervision 24 hours a day.

The occupational therapy department provides service for this and for other units of the hospital. The hospital recreation officer makes provisions for spare-time activities.



The active treatments consist of electroconvulsive treatment, antidepressive agents, and tranquilizers, as well as psychotherapy, which is practiced mostly in group form.

Electroconvulsive treatment, now a little less frequently prescribed than previously, is given in both modified and unmodified forms, rather more patients being given relaxants than unmodified treatments. The choice in favor of using a relaxant is usually made on the grounds of age over 40, cardiac condition, recent injury, or discomfort from unmodified treatment. A thiopentone, Brevidil (Suixamethonium) sequence is used with oxygen insufflation during the period of controlled respiration. Brevidil, a British product, is an ultra-short-acting relaxant, apparently not much used in the U.S.A. In this hospital's experience, it has practically no side effects and has a low incidence of prolonged apnoea.

The antidepressive agents currently in use are imipramine and phenelzine, which have obviated ECT in some cases. However, the medical staff tends to feel that the quality of recovery, both in level and permanence, is not always quite so good with these agents as with ECT. Owing to the hypotensive effects of the drugs, four-hourly blood pressure charts are kept for clinical and research purposes. A new antidepressive of the MAO inhibitor type is about to commence clinical trial at the time of writing.

In the field of tranquilizers, the drugs of the phenothiazine group remain the most favored. Those in use include chlorpromazine, promazine, perphenazine, and prochlorperazine; the clinical trials of fluphenazine are imminent. Reserpine-type preparations stay in use for only a few patients to whom they have seemed particularly suited. One of the main reasons for the relative abandonment of chlorpromazine was its tendency to cause contact dermatitis in the staff and solar photo-sensitivity dermatitis in patients during the long, dry Canterbury summers with their high sunshine hours. Perphenazine is now the treatment of choice for mania requiring control, but it is felt that its tendency to produce extrapyramidal side effects in those predisposed is a limiting factor in its usefulness, as in other piperazine substitution phenothiazines. The use of these phenothiazine derivatives has made the disturbed wards much more peaceful and enabled the rehabilitation of many chronic patients hitherto considered unsalvageable. Many ex-patients are maintained outside the hospital with the aid of tranquilizers, but, as no doubt many doctors elsewhere have already noticed, there are many defaulters in the taking of medication, who unfortunately relapse.

For acute anxiety there has been a tendency to revert to the barbiturates for quick control of a case during the first few days in the hospital until psychotherapy or other treatments become effective.

For chronic anxiety resistant to psychotherapy, physical treatments and tranquilizers are used; neurosurgery, especially leucotomy (lobotomy in the U. S.), is still being used with some success. The cases, now very much smaller in number due to a more rigid selection, have all been chronically tense, anxious subjects, mentally ill and unable to work for two years. To date, all cases have returned to work and they support their families unaided.

As elsewhere in the world, chronic alcoholism is a definite medicosocial problem. Sunnyside's contribution is inpatient treatment of the more difficult cases who have advanced beyond the resources of the private doctors and Alcoholics Anonymous. The treatment considered most appropriate is a total push method with Conditioned Aversion to Alcohol (C.A.T.A.) as its main-

spring. Wherever possible, modified insulin is used as an adjunct in cases requiring rapid weight improvement. Group psychotherapy, occupational therapy, sport and work therapy, plus the re-establishment of broken social links with more stable sections of the community, make up the rest of the program. Acute alcoholism is treated by the usual sedative and vitamin therapies.

Addiction to drugs other than alcohol is fortunately a comparative rarity in New Zealand, and the relative absence of a sophisticated underworld is probably an important reason for this situation. Nevertheless, addictions to narcotics and barbiturates and the newer synthetic "daytime sedatives" such as methyprylon have required treatment.

Group psychotherapy is conducted on the lines of psychiatrist-directed, verbal, superficial therapy aimed at insight through knowledge of the simpler mental mechanisms. The groups are open but some selection of members is made to ensure a reasonable homogeneity. Psychodrama is occasionally used in suitable cases where it is

felt that this method would benefit both the group and the actors. Films illustrative of mental mechanisms are also shown, a therapeutic method very popular with patients.

Owing to medical staffing difficulties, research at Sunnyside has to be an individual effort by each doctor. In their leisure time, staff psychiatrists are working upon such research projects as a study of the puerperal psychoses in Canterbury, or endeavoring to make observations upon the extrapyramidal effects of phenothiazine tranquilizers, as well as slowly launching plans for the nuclear sexing of selected patients. Meanwhile they are contributing articles to the New Zealand Medical Journal upon interesting cases. A mass of statistical material upon a muscle relaxant used in ECT is awaiting statistical treatment at present.

In the field of forensic psychiatry the hospital is quite active. Under the Mental Health Act of New Zealand, offenders may be admitted to a mental hospital from a Magistrates' (police) Court for observation; this results in a psychiatric screening of the repeated offender and the "idle and disorderly" (hobo) type as well as the true psychiatric delinquent. Psychiatric treatment is a recommendation in only about 50 per cent of the cases, but the courts find the investigations helpful and are prepared to accept psychiatric advice, where relevant, in their penal policies. Psychiatric examination of all murderers by Crown psychiatrists is another feature engaging the medical staff, who also frequently act as psychiatric consultants to Her Majesty's Prisons in the district as well as to organizations dealing with juvenile delinquency.

# The Chaplaincy Service

IAN B. WILSON *Presbyterian Chaplain, Sunnyside Hospital, Christchurch*

THE CHAPLAINCY SERVICE in New Zealand is on a denominational basis. The chaplains are appointed by their respective churches, who are responsible for their stipends, the Division of Mental Hygiene contributing traveling expenses.

For example, at Sunnyside Hospital, Christchurch, a hospital of 1,000 beds, there are Church of England, Presbyterian, and Roman Catholic chaplains. Both the Church of England and Presbyterian chaplains are full-time, but give part of their time to a neighboring general hospital. The Roman Catholic chaplain has parish duties outside the hospital.

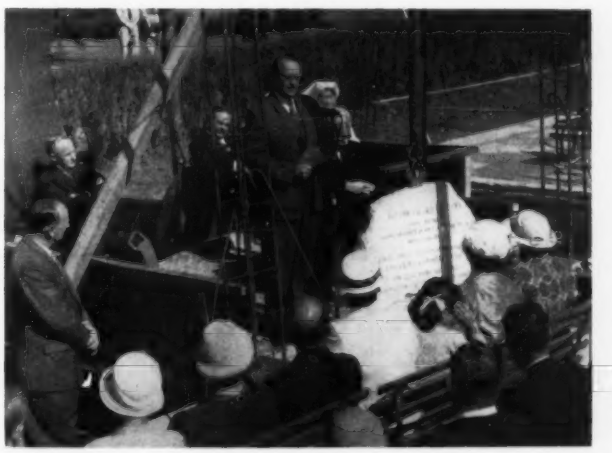
Hitherto no training facilities have been provided for chaplains, who have learned whatever skills they possess on a trial-and-error basis. Relationships with the medical staff have been excellent and the psychiatrists have patiently schooled the chaplains as they went along. Following the visit to New Zealand in 1959 of Dr. Seward Hiltner of Chicago, the first experiment in pastoral clinical training was conducted at Sunnyside and at Christchurch General Hospital in November and December 1959. In a six-week course, six senior theological students from four denominations worked in the hospitals with the accredited chaplains.

Any scheme of training which gives the chaplain new insight and a better understanding of the patient and his needs is advantageous. The New Zealand Division of Mental Hygiene has made it clear that it does not wish its chaplains to be pseudo-psychiatrists. The chaplain has his own special field: he works as part of a team of which the psychiatrist is the recognized leader. The duties of a chaplain as they are envisaged in the New Zealand mental hospitals are, in a large measure, the duties of a parish minister, carried out among a special group of people in a special sphere: the conduct of public worship; the administration of the sacraments; visitation; counseling.

There is no group of people more reverent, more alert to receive the blessings of their church than the men and women patients at Sunnyside Hospital.

The one aspect of the chaplain's work in New Zealand which might be considered unusual, or at least different, is in the area of social service. Here the chaplain serves as a link between the hospital and the outside community, sponsoring such cooperative activities as libraries, adopt-a-patient programs, church socials with patients as guests, concerts, dances, group singing, etc.

The new interest and goodwill that are developing in the general community towards psychiatric hospitals and their patients were undoubtedly reflected in an appeal made last year in Christchurch to raise $17,000 for a chapel and chaplains' offices at Sunnyside Hospital. The staff and patients themselves raised $2,000, and within six months the remainder of the money was raised by public subscription. The interest in this appeal was widespread. From the days of Captain R. F. Scott, whose Antarctic expeditions in the early part of this century were based at Christchurch, its citizens have had a special interest in the Antarctic. A suggestion to Rear Admiral



David M. Tyree, Commander of the United States "Deep Freeze" Expedition, also based at Christchurch, that a stone be brought from the Antarctic as a foundation stone for the chapel, met with an immediate response. Blocks of marble from "Marble Point Antarctica" were flown out by helicopter and freighted from the Antarctic to New Zealand by the U.S.N. tanker "Alatna." When this stone was laid by Viscount Cobham, the Governor-General of New Zealand, Rear Admiral Tyree and his aide were present to represent the United States Navy at the ceremony.

Mental hospital chaplains in New Zealand are men new to their trade, always learning, always with much more to learn. They are not specialists—for most of them have had no special training—but are essentially parish ministers working in special parishes. In these special parishes which are mental hospitals, they are constantly gaining new insights into human need and the meeting of human need, and they are constantly grateful for the opportunity that is afforded them to contribute some measure of Christian love and care within the hospital community.

# The Nursing Service

M. E. LITTLE, O.B.E., N.Z.R.N., R.P.N.
*Sunnyside Hospital, Christchurch*

THE GREAT MAJORITY OF NURSES in the New Zealand hospitals are either qualified psychiatric nurses or nursing trainees. The curriculum for the training of psychiatric nurses, both male and female, is of three years' duration. The content is based on the curriculum for general trained nurses as it effects basic nursing services, public health, social services, and nursing arts. Psychiatry, functional nervous disorders, psychiatric nursing, and the care of the mentally deficient child have been added. Male and female staff in training take the same lectures and the same examinations. At Sunnyside, two classes are taken in each year, one in March and one in September.

A First Professional Examination is taken at the completion of 9-12 months' training. This consists of a three-hour written examination in psychiatric nursing. A Hospital Examination and a Final Professional Examination are undertaken at the end of the course. Each of these consists of a three-hour written examination in psychiatric nursing, a two-hour written examination in psychiatry, and an oral and practical examination in psychiatry and psychiatric nursing.

General trained nurses are accepted for psychiatric training and are granted a concession of one year. Likewise, registered psychiatric nurses receive a year's concession if they take their general training. Every encouragement is given for them to do this to enable them to obtain the double qualification.

Some married women who can work only part time because of family responsibilities serve as assistant nurses. They render a valuable service. Younger girls who are interested and suitable may be employed as hospital aides until they attain the age of 18, when they can commence nurses' training.

# The Community

DAVID LIVINGSTONE, M.B., Ch.B.,
*Christchurch*

IN THE PROVINCE OF CANTERBURY a mental health council has been formed with the aims and objects of raising the level of knowledge among all scctions of the community about the facts of mental health and disease; encouraging research into mental health and disease; and assisting in every way, individuals and agencies, voluntary and governmental, already working in these fields. The constitution of the Canterbury Mental Health Council is probably unique. Below are some of the organizations to which members of the council belong: The professions of medicine, nursing, the ministry, law, accountancy, and teaching; Canterbury University Council and staff as well as the undergraduate body; Junior and Senior Chambers of Commerce and the Canterbury Manufacturers Association; the National Council of Women; The Plunket Society; the Rotary and the Lions Clubs; the Public Service Commission; the Trade Unions; the Health Department; the Mental Health Association; the City Council; the New Zealand Broadcasting Service; and the Returned Services Association. The council was organized early in 1960 and, shortly thereafter, was incorporated under the Charitable Trust Act. After council members had considered the ways in which they could begin work for mental health in Christchurch (the major city in the Canterbury area), they decided the first project should be in the form of a community-wide educational program.

Plans have been made for a mental health education program lasting two weeks in September 1961. The first week will be devoted to professional groups, the second to the lay public. It is felt that nonmedical professional groups, such as clergy, lawyers, nurses, and school teachers, as well as medical practitioners, psychologists, and social workers should participate fully in the first week's learning experience since all have vast social responsibilities in their daily work. There will be specific teaching designed toward meeting the needs of general medical practitioners and of those whose work brings them into daily contact with people seeking professional help for emotional or mental disability. However, it is thought desirable to have combined meetings at which these people will sit with educators, lawyers, police officers, and ministers of religion. If we are to work towards the prevention of emotional disorder, it is necessary that each of the various groups should understand the roles and attitudes of the others and learn to work harmoniously with mutual respect and in close cooperation.

On the professional education committee of the council are the following: psychiatrists (private and from the state mental hospital); a psychologist; representatives of the British Medical Association and the College of General Practitioners; a professor of law; the Dean of the Anglican Church; a health education officer; a registered nurse; a public relations officer; and an undergraduate student. Other committees are considering programing for the education of women's groups, parents, adolescents, employers and employees in business and industry, and the "man and woman in the street." All media of transmitting information will be utilized in reaching the community as a whole.

It was felt desirable to invite lecturers from outside New Zealand as well as utilizing available local talent. Because of our geographic seclusion, travel to New Zealand, especially from the Northern Hemisphere, is relatively costly. Funds were first made available to the council through the activities of the students of Canterbury University. Each year the students organize a traffic-stopping procession of decorated floats with amusing, topical, and frequently bawdy themes. This annual event in the "Garden City" is keenly awaited by young and old alike, who line the streets in thousands and generously contribute to whatever charity has been selected by the

students as being particularly worthy of their support. This year the students collected 4,000 pounds (about $12,000) on "Procesh Day" and donated the entire proceeds to the Mental Health Council. The support given in this way by the forward-looking students was recognized by the press and the public and has created much interest in "Operation Floodlight," as the mental health educational fortnight is to be called. Further financial assistance has been offered by Smith Kline and French, Pfizer, and Geigy pharmaceutical firms. As a result several visitors from outside the country are to strengthen the cadre of local lecturers. Acceptors include Dr. Alan Stoller of Melbourne, Professor W. H. Trethowan of Sydney, Professor Ferguson Rodger of Glasgow, and Dr. Daniel Blain of California.

It is hoped that the work of the Canterbury Mental Health Council will favorably alter the climate of public opinion about mental illness, and make the task of professional workers easier. This may apply particularly in respect to the rehabilitation of men and women who have been inpatients in mental hospitals. Reduction of ignorance about mental illness, criminality, delinquency, and alcoholism, for example, can reduce feelings of guilt and unworthiness in the afflicted, as well as fear in the community and in families in reaccepting them after therapeutic endeavors have been made. The Council will give special attention to the mental health of young children in the family situation, realizing fully the influence of the earliest years of life on personality. •

# *A Psychiatric Preceptorship for Medical Students*

By KURT WOLFF, M.D.
*Assistant Director, Professional Services for Education*
*VA Hospital, Coatesville, Pennsylvania*
*Associate in Psychiatry*
*University of Penna. Medical School, Philadelphia*

DURING THEIR TRAINING in medical school, medical students attend a large number of lectures on the symptomatology and etiology of mental sicknesses, but they rarely interview psychotic patients or enter into personal relationships with them. They learn very little about ward management, administrative methods, and the different therapies as applied on an individual basis. Furthermore, the case work-up of a patient, case presentations and discussions by the psychiatric team, the team approach to the patient's treatment, and the problems of remotivation and rehabilitation are seldom experienced by medical students. These gaps in their training might easily lead them to mistaken conceptions and undue skepticism of psychiatric treatment and procedures.

As a result of numerous discussions on this subject with medical students of two universities (the University of Pennsylvania Medical School and the Women's Medical College in Philadelphia) and with their teachers in psychiatry, a special psychiatric teaching program has been conducted at the Veterans Administration Hospital at Coatesville, Pa., for the past two years. It appears successful in giving medical students, who attend during their third or fourth year of training, a better understanding of psychiatric problems. It interests them in psychiatry generally, and stimulates some of them to think about a psychiatric residency later on.

This preceptorship type of program lasts for three weeks—the minimum time needed, in the author's opinion, for a good introduction to general psychiatry. A period of less than three weeks duration is conducive only to greater confusion and many misunderstandings.

During the preceptorship period at this neuropsychiatric hospital, medical students are given a series of introductory lectures during which they learn how to prepare a psychiatric case-history; are familiarized with the definition and meaning of delusion, illusion, hallucination, insight, anxiety, defense mechanism, and other major psychiatric concepts; become acquainted with the significance of neurotic, behavioral, and psychotic reactions; and learn about the basic criteria of the different forms of mental sickness.

Students are assigned two patients from the admission ward for case work-ups with prognosis and treatment recommendation. Careful selection is made in order to expose the students to a variety of psychopathologies. They gain knowledge of male and female patients suffering from schizophrenia, manic-depressive psychosis, involutional psychosis, chronic brain syndromes associated with cerebral arteriosclerosis, and psychosomatic and psychoneurotic disturbances.

At the end of this period the students are requested to present the case-histories they have prepared. At this time the patients are interviewed and their prognosis, treatment, and disposition are discussed in a meeting at which all medical students and a psychiatrist are present. During this meeting the most important features of the patients' psychodynamics are pointed out.

In addition to the case work-ups, the students get special assignments on the ward. They are divided into groups of two and follow a preceptor on his early morning rounds to observe a variety of patients. Questions and comments are encouraged, and through these and observation, students learn about psychopharmacological drugs; about the techniques of electric shock treatments, and its indications and contra-indications; about the meaning of control and privileges; and about assignments of patients to occupational, industrial, and recreational activities. Students are advised to study the daily schedule of some of the patients and be with them as often as possible during the day. Then the students take part in diagnostic and disposition staffs with their preceptors and get acquainted with the methods of the team approach, including social service, nursing service, psychology, adjunctive therapy, and volunteer service.

## INTRODUCTORY LECTURES

In addition, the medical students participate in a special lecture program as a phase of their introduction into psychiatry. Judging by the author's experiences, it is advisable to teach medical students an eclectic approach to mental sickness. Therefore, three introductory lectures about the biological, sociological, and psychological approaches to mental sickness appear to be appropriate. It is also useful to discuss with students the meaning and importance of emotional health in general. The psychosomatic aspects of emotional sickness and the fact that psychiatry is a respected, logically sound branch of medicine are emphasized. Also at this time the differences between those case work-ups regarding physical problems and those regarding emotional problems are pointed out.

Furthermore, the medical students at the hospital are welcome to attend lectures and seminars given for residents in training by the psychiatric staff and consultants from different universities. This enables students to learn more about child psychiatry, theories of psychosexual development, the origin and dynamics of schizophrenia, geriatric psychiatry, and the basic principles of group and individual psychotherapy. The students are also invited to attend residents' seminars to learn the technique of the psychiatric interview, or to accompany psychiatric consultants who are interviewing patients offering special problems of diagnosis, treatment, or disposition. Here,

the psychiatric consultant explains to the students the problems to be investigated and the reasons for his decision or recommendation.

Finally the students are encouraged to read some of the basic books on general psychiatry during the evening hours.

In this way the interest of the medical students, who are frequently shy and inhibited at the beginning of the program, is stimulated, and their depreciation and suspicion of psychiatry are decreased. They begin to understand the importance of emotional disturbances in everyday life and to recognize that the cooperation of the general practitioner and medical specialists with the psychiatrist is conducive to a better understanding of their patients' symptoms and cure. They also become aware of the role of the social environment, both family and community, in the etiology of medical and emotional problems, and of the crucial importance of proper readjustment for their patients in their families, employment situations, and communities.

I believe that this method of psychiatric teaching is a successful and valuable addition to the training of medical students. It helps them to become more aware of emotional problems involved in patients' illnesses, and thus promises better treatment of their own patients in the future.

# *ANATOMY OF AN ADMINISTRATOR*

By DR. WHATSISNAME

In its Report No. 46, the Group for the Advancement of Psychiatry has a cartoon[1] showing the anatomic structure needed by a good superintendent. This is fine as far as it goes, but let's face it—man is simply not properly structured for management. He has to keep his shoulder to the wheel, which is hard to do when he has to keep his fingers in the pie (and also on all the reins) while on the other hand, his fingers must be constantly on everybody's pulse.

Then, he needs three feet. One he must keep in the door, and the other two feet have to be firmly planted on the ground. What will this do to his back? It has to be a back so tough that nobody can stab him in it. This means a firm backbone which every executive is supposed to have—though with that shoulder to the wheel this takes some contorting. How about his face? He must keep it intact, for no superintendent can afford to lose face, even through his skin (or hide) has to be tough. His nose has to be long enough to poke into everything, but it must never get out of joint. Since the good executive needs some cynicism, his tongue must be in his cheek—and he'll need plenty of cheek to keep his job. He has to know when to keep his mouth shut, even if he has to sink his teeth into problems; which is tough going, especially when nothing may stick in his crop. His skull must be firmly planted on his shoulders, for he must never lose his head; and while he should not have to bend his neck, he must be willing to stick it out from time to time, meanwhile, keeping the area beneath his mouth well armored so he can take it on the chin. (No room for a glass jaw!)

Now let's get inside this man. He cannot be lily-livered (or chicken-livered if you put it that way), and he must not vent his spleen. He needs bowels of compassion to keep his heart from being pulled too hard. His heart, by the way, is a busy little organ. It must be not too soft and not too hard; but the administrator has to be big-hearted. While his heart has to be in his work, it must also be in the right place.

His digestive cavity must be firm enough to stomach anything, while the bile that might rise within him must be kept covered with some phlegm. His blood has to be thermostatically controlled so that he can be warm-blooded or cold-blooded as the situation requires.

And if that isn't enough, remember every executive must be constantly on his toes.

[1] *Administration of the Public Psychiatric Hospital, Rep. 46, G.A.P. p. 170.*

# A Case History of...

# *PANIC!*

By DANIEL LUCAS, Ph.D.,
*Clinical Psychologist*
and RICHARD G. LUDWIK, M.S.
*Clinical Psychology Trainee*
*VA Hospital, Northport, New York*

PARTICIPATING in a controlled group therapy session as a patient in a mental hospital is admittedly quite different from mingling with the people on the streets outside. But both of these situations produce experiences which in turn interact to the good or ill of the patient. A recent series of events at this hospital dramatizes the importance and possible effects of such interaction.

One of our men in group psychotherapy had many phobic symptoms with periodic related anxiety attacks. Prominent among these was his literal inability to leave the hospital, even on a short pass to a nearby town. He would approach the hospital gate and halfway there would break out in a cold sweat, experience heart palpitations, and, with an upsurge of intense anxiety approaching panic, would have to retreat to his ward. A further factor was his having had a series of severe rejections by important people in his life, as well as rejection as a Jew in Nazi Germany.

This patient expressed a primary feeling in group therapy sessions that he could not trust anybody and that people cared only about themselves. He was consistently sensitive to what he perceived as others' rejection of him. For example, he was late to one group session and before he came in another patient began talking about this man's unwarranted sensitivity to an incident that had occurred on the ward a few days previously. Our patient had been told by three others that they already had a fourth player for a prospective card game. He reacted as though he had been personally rejected, seemed extremely hurt and angry, and walked away in a huff. At this point the patient under discussion entered the group-therapy room and in the ensuing conversation angrily said it was obvious that the card-playing patients did not care for him or his feelings. He felt especially hurt because one of the players was a fellow group-therapy member. It was brought out that his feelings of personal rejection were unjustified, since the fourth player had already agreed to play and was only momentarily detained. Our man finally conceded that he had jumped to conclusions. The other patients in the group further pointed out that his manner was such as to invite rejection and counter-hostility. Although he "recognized" this, he tried to defend himself by extensive rationalization.

Two days after this session, our patient, who had obtained staff approval for a week-end off-the-grounds pass several weeks previously but had been afraid to go, decided to try to make it to a neighboring town. He had called a cab and was waiting for it to arrive when one of us accidentally met him in the lobby. He was perspiring quite freely, and was obviously quite anxious even after he was given support and reassurance. What follows is the patient's own description of what happened that Friday.

He rode in the cab to outside the hospital gate when suddenly he panicked and became quite frightened. He asked to be taken back to the hospital canteen. He had the cabbie wait and he went into the canteen and drank some coffee until he calmed down. Finally, he returned to the cab and decided to confide his difficulty to the cabbie. The driver said he understood and told the patient he would help him get to town. They drove slowly out the gate with words of reassurance from the driver, and finally made it to town. The cabbie took the patient to a local restaurant, introduced him to some friends, and arranged for him to be able to lie down if he needed it. He told the patient he would return in fifteen minutes, and to wait for him. When he returned, he picked up the patient and for the rest of the morning and afternoon either drove him around with his fares, or had him wait in a restaurant or diner where he always made sure to introduce him to some friends. At one time, the cabbie tried to help the patient walk through the town by himself. He suggested letting the patient off at one end of the main street, and said that he would drive through and meet him at the other end. The patient started off but about halfway along he began to panic, whereupon the cabbie pulled up beside him and helped him back into the cab. He had been following the patient without the patient's knowing it and had detected his mounting fear. Toward evening, the two had dinner together, Dutch-treat. When they returned to the hospital, the driver "charged" the patient one dollar for the whole "trip."

In the next group therapy session following this incident, the patient was encouraged to talk about the event. He began to connect his feelings about it with his feelings and behavior in the card-playing incident, in the group, on the ward, and in his other life experiences. He finally declared, "The evidence is overwhelming, I guess you can trust people. Maybe they can care about you after all."

The patient is still subject to the phobic feelings about leaving the hospital. However, within several weeks of the taxicab incident, he was able to go out on a one-day pass to the neighboring town and at the end of the day called in for a two-day extension. He slept over in a hotel and said he felt like staying longer. He continues to express more strongly the feeling that others are friendly, and members of the psychotherapy group have commented that he has been acting more friendly on the ward.

Permanent personality or behavioral changes would hardly be effected so readily. However, the unusually kind effort of the cabbie in the community tied in meaningfully with what was going on in group psychotherapy and on the ward. The incident serves to highlight the importance of the interrelationships between the many environments in the treatment of the mental patient. •

# KEEP THE FAMILY IN THE PICTURE

By BETTY KEENAN
*Director, Hospital-Community Services*
*Morningside Hospital, Portland, Oregon*

NEXT TO TELEPHONES AND TYPEWRITERS, two cameras are the most frequently used pieces of office equipment in our hospital. One of these is a Polaroid model which our office personnel quickly became as adept at operating as they are at typing, transcribing, and filing. It is used almost daily in answer to requests from patients to have a portrait to send home, or from families for a pictorial report on how their loved one is doing. New patients are routinely photographed with the Polaroid shortly after admission, and the picture is inserted in the patient's record. Very often a copy of this picture is sent to the family with the first letter from the medical director as added reassurance that the patient has arrived safely and is adjusting comfortably to the hospital.

One of the early letters to the family also contains a colored snapshot of the patient's ward and perhaps of the school, O.T. shop, cafeteria, or some other activity area in which he is involved. Many of these are taken with the hospital's second camera, a Kodak 35 mm., which is used primarily to record in color the various activities and special events which take place. The activity pictures serve a specific purpose which will be described later, but copies are frequently sent to families if they happen to pertain to a patient currently under discussion in correspondence.

We also send color portraits taken with the 35 mm. camera if we feel that a little extra "glamor" is needed to interest or reassure the family. One instance where we would do this is when we are trying to encourage a relative or a prospective foster home to accept a patient ready for release.

There is little difference in cost between the two types of pictures. The Polaroid camera has the advantage of producing immediate individual prints, whereas the 20-exposure rolls of color film used in the Kodak often cause a delay of several weeks in getting a print to send. Even though we get a 10 to 20 per cent discount on developing and supplies by dealing with wholesale firms, this is not an inexpensive venture. Each picture costs about 45¢. The appreciative responses from the families and from the patients themselves convince us, however, that it is cheap at the price.

The color shots of facilities and activities are used for a number of purposes. We have made up five identical albums showing what the hospital looks like and how the various programs operate. Each of these is entitled "A Pictorial Tour of Morningside Hospital." Since nearly all of our patients come from Alaska, three of the albums have been sent to the state screening centers at Anchorage, Fairbanks, and Juneau, to show incoming patients and their relatives what to expect.

I know from personal observation how much this preparation can mean. Two summers ago I happened to be visiting the Anchorage office of the Alaska Department of Health when a woman about to be sent to Morningside was being interviewed. The A.D.H. psychiatrist and social worker were attempting to convince Nell and her husband of the necessity of hospitalization on a voluntary basis. Nell, however, was both resistant and extremely fearful, since she had only bad memories of her previous hospitalization in one of our country's largest, most overcrowded institutions. The social worker turned her over to me to show her what Morningside looks like, and I could see her apprehension melt as she looked at the color photographs of our hospital's cheerful decor and busy activity program. Afterwards, worried that I had "oversold" her in my desire to be comforting, I made a point of asking her when I got back to work (she had preceded me to Portland by two weeks) whether I had misled her. It was Nell's turn to reassure me, and she declared that the hospital was all I and the photographs had claimed it would be. Our hope, of course, is that the albums and the mailed photographs will be as helpful to other patients and their relatives as they were to Nell and her husband. (By way of postscript, when Nell returned to Anchorage a month later she volunteered to address a public meeting concerning Morningside which was being held by the Alaska Mental Health Association, and proved to be a most enthusiastic booster. I like to think that the photograph album helped to persuade her to come to us for help when it would be most effective, and that she in turn helped persuade others who might need psychiatric care.)

## EXHIBIT FOR RECRUITMENT

The two albums which remain at the hospital serve a variety of purposes. One is on seasonal loan to the American Friends Service Committee's Portland office and is used by their college projects coordinator when she travels to colleges throughout the state to recruit participants for A.F.S.C. volunteer projects at Morningside. The other is taken by staff members to the various professional meetings they attend and employed as an "instant exhibit" on our program. It is also sent on loan to prospective staff members who live too far away to visit the hospital before making a preliminary decision about joining us.

In addition to the albums, we have had a series of colored slides made of representative views to show to community groups who are interested in doing volunteer work here, or just in mental health care in general. Personal visits are preferred, of course, but sometimes it takes these pictorial previews to get people sufficiently interested (or again, reassured) to come in person.

# *REVIEWS & COMMENTARY*

## FILM REVIEWS

*Supplemental film catalogues with order blanks for four new films were sent to full subscribers to the A.P.A. Mental Hospital Services early this month. Included are: "The Owl and Fred Jones" (reviewed in* MENTAL HOSPITALS, *November 1960); "Natural History of Psychotic Illness in Childhood" (reviewed in December 1960); "Booked for Safekeeping" (reviewed in this issue); and "Psychiatric Nursing–The Nurse-Patient Relationship." Subscribers who may want to borrow these films and 26 others are reminded that order blanks must accompany their requests, otherwise the orders will not be filled.*

BOOKED FOR SAFEKEEPING (black and white, 33 minutes) Produced jointly by the Louisiana Association for Mental Health and the National Institute of Mental Health. Available from the Mental Hospital Service Film Library to all full subscribers to the service.

Intended as a training film for police officers, this excellent new film illustrates some humane and safe methods of handling excited mentally ill persons. Its theme is:

*A scene from "Booked for Safekeeping"*

treat every person as if you are to handle him again, as indeed you may! Produced in a starkly documentary style, it does not depict ideal physical conditions because it recognizes that most communities have to give their mentally ill emergency care with inadequate facilities. The film stresses the basic points of proper handling of excited persons: calmness, candor, consideration, honesty, psychological deterrence when possible, and gradual release from restraint. The needs of both the police officer and the mentally disturbed person are kept in mind.

Planned by Loyd W. Rowland, Ph.D., executive director of the Louisiana Association for Mental Health, the film was made as a direct result of the unusual success of Dr. Rowland's booklet, "How to Recognize and Handle Abnormal Behavior." This booklet was an outgrowth of his pioneering program for instructing the New Orleans Police Department in caring for mentally ill persons before they can be placed in a hospital. Production of the film was made possible by a grant from the National Institute of Mental Health after Dr. Harold Hildreth of N.I.M.H. had investigated and learned that a film would be a useful supplement to the police manual now being used in training police officers throughout the country. The script and direction are by George Stoney, who has made many notable films in the educational and health fields. Using only members of the New Orleans Police Department, instead of professional actors, Mr. Stoney has wrung from them some startingly realistic performances. The planning of Lucien Cutrera, captain of the First Precinct (which includes the Bourbon Street beat), in the leading role ranks, in this reviewer's opinion, as the best example of perfect casting on record. The captain plays his real-life role with seeming indifference to the presence of the camera, but–more importantly–he is exactly the kind of person with whom police officers would be likely to identify while watching the film. "Booked for Safekeeping" is a film which should make all its collaborators feel justly proud of the effort involved.

This film will be valuable for all mental hospitals and community psychiatric facilities to use as a training

film for their law enforcement personnel who bring mentally ill persons to the hospital, or who hold mentally ill persons in detention centers prior to commitment. It will also be useful in orientation programs for nurses, psychiatric aides, and hospital employees who may come into contact with disturbed patients. It would probably not be suitable to show to the general public but could be used with certain community groups to enlist support for mental health training courses for police officers. In any case, a discussion leader should be present to handle questions following the showing.

JACK NEHER
*Mental Health Materials Center*

## READERS' FORUM

**Progress Report**

I thought you might like a progress report on developments in the Department of Psychiatry here at the Cedars of Lebanon Hospital. It has been an extremely exciting year and many new programs have been initiated. Our inpatient and day-night care service opened on September 12, 1960. It consists of 21 full-time beds and four night beds, and accommodates seven day-care patients. It is located in the main hospital building, which I consider a definite advantage, as it greatly facilitates the integration of all medical services. We have been able to expand the services of Cedars' Outpatient Psychiatric Clinic, which has been active for many years. Despite this, we are far from being able to meet the great need for psychotherapeutic and other services, even of the Cedars general population.

Our residency training program began on July 1 and we now have four residents, two of whom are on a one-year rotation from the Brentwood VA Hospital. The Julia Ann Singer Therapeutic Nursery School in a beautiful new building on the hospital grounds will become the basic facility in our child psychiatry program. It is financed by the Julia Ann Singer Foundation and the Community Chest, and will function in conjunction with the Child Psychiatry Clinic at Cedars. The Department of Pediatrics, in conjunction with the Department of Psychiatry, has begun to operate what we like to think of as an adolescent health center. It is serviced by a panel of physicians in different specialties, and we hope that it will develop into an active adolescent study center, although its beginnings as yet are modest. Other items include a new psychosomatic clinic which is to start in January.

The new million-dollar Cedars Research Foundation, partially financed by NIH matching funds, is in its final planning stages, and we in the department are looking forward to obtaining much-needed laboratory facilities in this building. A number of research projects are being planned, and I hope that an active research program will be initiated in many areas during the coming year.

The full-time staff of the department has grown, and, besides myself as director, it now includes three

psychologists, one of whom is a child psychologist, and five social workers. For teaching and service we rely heavily on our voluntary attending psychiatrists, who have been most generous in giving of their time.

Our basic philosophy in establishing these new programs has been to work towards an active integration of psychiatry with teaching, research, and service programs throughout the hospital. One of the outstanding features in all our undertakings has been the tremendous backing and support the department has received from the administration and the whole medical staff, for which we are deeply grateful.

JOHN GUSSEN, M.D.
*Los Angeles, California*



# BOOK REVIEWS

IMPRESSIONS OF EUROPEAN PSYCHIATRY—by Walter E. Barton, M.D., Malcolm J. Farrell, M.D., Frances T. Lenehan, R.N., William F. McLaughlin, M.D., American Psychiatric Association, c-140 pp., $3.50.

American psychiatrists, and especially those working in hospitals, will welcome the publication of this important book on European psychiatric practice. Although it was originally written as a report for limited distribution, its reception was so favorable that early readers quickly suggested that it receive the wider audience it so richly deserves.

There have been many reports on European psychiatry published during the past six years, but none as comprehensive, as readable, as informative, or as accurate as this. The four authors, representing two mental hospital superintendents, one superintendent of a state school for retarded children, and a chief supervisor of psychiatric nursing—all from the Massachusetts State Department of Mental Health—made their intensive six-week tour in 1958. The trip was arranged by Jack R. Ewalt M.D., then commissioner of mental health, and supported by the Commonwealth Fund. The authors visited some forty-seven institutions in Great Britain, Belgium, Denmark, France, and Holland.

The four authors have approached their task with skill born of years of hospital experience. The wide range of questions they asked and the logical way in which the answers are organized will please the most discerning. Their evaluations are critical but fair, and they do not omit a single important item. Community psychiatry, rehabilitation, the medical and psychiatric care of failing old folks, the institutional management of psychotic children, mental retardation, the care of criminal psychopathic personalities, nursing programs, and mental hospitals were the principal areas studied.

As an independent observer who has visited representative hospitals in all the countries mentioned, the reviewer can vouch for the completeness and reliability of the reporting. The authors avoid the pitfalls of the

overenthusiastic and uncritical visitors who praise abroad and condemn at home. Furthermore, they have not hesitated to speak out frankly on both the advantages and problems of the national health programs, a subject which many observers tend to overlook. Representative case histories give life to the description of the home service program of the famous "Amsterdam Plan." Salary scales for personnel, incentive pay for patients, working hours for nurses, details of work therapy, and problems of the "open hospital" are all carefully listed.

"Are European patients better behaved than American patients?" "Does the Worthing Experiment really work?" "Are American psychiatrists as well trained as their European colleagues?"

"Has European psychiatry solved the nursing shortage?" "What hospitals should I visit and to whom should I write concerning my trip to Europe next year?" These and scores of other such questions, which have occurred to the perceptive American psychiatrist, are neatly and concisely answered in this informative volume.

It can be heartily recommended to all psychiatrists who are interested in gaining new ideas for improving patient care and should be required reading for all who are contemplating a trip to Europe in the near future.

ZIGMOND LEBENSOHN, M.D.

*ATTENTION! "Impressions of European Psychiatry" is being offered by the Publications Dept. of the American Psychiatric Association at the special price of $3.00 for all orders mailed before January 15 to 1700 18th St., N.W., Washington 9, D. C.*

MENTAL HEALTH EDUCATION: A CRITIQUE—Published by and obtainable from the Pennsylvania Mental Health, Inc., 1601 Walnut Street, Philadelphia 3, Pennsylvania, May, 1960, 180 pages, $1.

This is an unusual book because it reports an unusual conference, the National Assembly on Mental Health Education, held at Cornell University, Ithaca, New York, in September 1958. The assembly was cosponsored by the National Association for Mental Health, the American Psychiatric Association, and the Pennsylvania Mental Health, Inc. A special grant from Smith Kline and French Laboratories made possible the publication of the report.

The assembly met to consider educational activities supposed to be useful in preventing or minimizing mental illness or designed to improve mental health. Much time, effort, and money are currently being expended in mental health educational activities. Goals of this education and the methods used are diverse and based on varying theoretical constructs. The assembly met to see if they would find agreement on (1) A definition of mental health, (2) At what goals should mental health education be directed?, (3) What principles of mental health have enough support in scientific findings and clinical experience to support a mental health educational program built on them?, (4) Are certain educational techniques to be preferred?, (5) What research ideas and proceedings seem most promising?

To put it briefly, the assembly could not agree; from reading the report and between the lines, it must have been quite a lively meeting. But the meeting did produce a number of working papers and some excellent thinking and discussions, the reading of which is stimulating and provocative.

The report is assembled in two parts. The first relates the proceedings of the assembly, and the second part summarizes the working papers. The book presents brief synopses of current mental health concepts from Freud through Sullivan, Fromm, Erikson, Mowrer, and others. There is a description of current practices in mental health education from posters to leaflets to comic books to TV, and the concepts underlying their use. There is a bibliography with 187 titles.

This is a valuable book for all who are interested in the fields of mental illness or mental health, or just interested in what the experts think about how people tick. It will be useful to the teacher and to the student alike because it contains a tremendous amount of material put together succinctly and meaningfully. And it is just plain interesting reading.

The editorial staff for the report included Mr. Michael Amrine, Elaine Cumming, Ph.D., and Mr. Max Silverstein. In the opinion of this reviewer, they did a fine job.

LUCY D. OZARIN, M.D.



## NEW PRODUCT

### Modern Door-Closers for New Buildings

Almost every hospital throughout the country is involved in current or long range plans to modernize existing facilities or build new ones. No one who has already experienced such construction efforts can forget the importance of those so-called "small details," the minor fixtures and furnishings, or deny that they should, in addition to being functional, remain in harmony with the new ideas in overall form as expressed by the architect and contractor. Turning to just one of these "small details," door-closers, we'd like to point out that they need not be of the unsightly standard shape used during the last half century.

For instance, newly designed rectangular door-closers by *Sargent* help to preserve the beauty of modern innovation in architecture. Moreover, they provide greater strength and are more adaptable to a broader range of installation situations. The rectangular door-closers may be mounted *within* the door itself, completely concealed in a metal door, or covered with a neat looking metal plate when installed in a wooden door. These door-closers come in all weight sizes and are particularly suited to entrance doors in modern buildings. They also will dress up the appearance of entrance doors in older buildings. The model tested was the *Sargent*, Model 52, on 1¾ inch doors.

For further information on this and other models address your inquiries to Sargent and Company, New Haven 9, Connecticut.

ALEXIS TARUMIANZ

# NEWS & NOTES

**A.P.A. Staff Listens and Looks**

The inservice education program for the staff of the Central Office began its second year of operation with a lecture from a distinguished visitor from Australia and a showing of two new films from the M.H.S. Film Library.

John D. Russell, M.D., Ch.M., D.P.M., president-elect of the Australasian Association of Psychiatrists, which includes New Zealand, spoke on psychiatry in his own country, and described his recent trip to the Soviet Union and Scandinavia.

The new films were "SKF Psychiatric Newsreel No. 2" and "Booked for Safekeeping." The former took the staff on a quick trip to unusual mental health facilities in England, Kentucky, and California; and the latter gave them an insight into the problems policemen face in dealing with mentally ill persons.

## Quarterly Hospital Professional Calendar

**A.P.A. ANNUAL MEETINGS:**

1961 May 8-12, Hotel Morrison, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

**A.P.A. MENTAL HOSPITAL INSTITUTES:**

1961 Oct. 16-19, Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)
1963 Cincinnati, Ohio. Dates & hotel awaiting confirmation. (15th)
1964 Sept. 27-Oct. 1, Hotel America, Boston, Mass. (16th)

**OTHER A.P.A. MEETINGS**

A.P.A. Executive Committee, *March 4*, A.P.A. Central Office, Washington, D. C.

OTHER PROFESSIONAL ORGANIZATIONS:

ACADEMY OF RELIGION AND MENTAL HEALTH, Annual Meeting, *January 18-20*, Biltmore Hotel, New York, N. Y.

COUNCIL ON MENTAL HEALTH OF THE A.M.A., Annual Conference of Mental Health Representatives of State Medical Associations, *January 20-21*. (Inq. Walter Wolman, Ph.D., Acting Secretary, A.M.A. Council on Mental Health, 535 N. Dearborn St., Chicago, Ill.)

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, Annual Meeting, *January 23-24*, Safari Hotel, Scottsdale, Phoenix, Ariz.

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, Annual Conference, *January 25-28*, Henry Hudson Hotel, New York, N. Y.

WORLD HEALTH ORGANIZATION, 14th Assembly, *February 7*, New Delhi, India.

AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION, Annual Meeting, *February 24-25*. (Inq. F. A. Freyhan, M.D., Secy., 503 Medical Arts Bldg., Wilmington, Del.)

GUILD OF CATHOLIC PSYCHIATRISTS, *February 25-March 1*, Miramar Hotel, Santa Monica, Cal.

CONSOLIDATED VETERANS ADMINISTRATION HOSPITAL, North Little Rock Division, Annual Institute in P. & N., *March 2-3*, VA Hospital, Little Rock, Ark.

NATIONAL HEALTH COUNCIL, Forum and Annual Meeting, *March 13-17*, Waldorf-Astoria Hotel, New York, N. Y.

AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY—Examinations for Certification in Psychiatry & Neurology, *March 20-21*, New Orleans, La.

AMERICAN ASSOCIATION OF PSYCHIATRIC CLINICS FOR CHILDREN, Annual Meeting, *March 22*, New York, N. Y. (Inq. 250 W. 57th St., NYC 19.)

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS—Annual Karen Horney Memorial Lecture, *March 22*, New York Academy of Medicine.

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY & PSYCHODRAMA, Annual Meeting, *March 22-24*, Barbizon Plaza Hotel, New York, N. Y.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Annual Meeting, *March 23-25*, Statler-Hilton Hotel, New York, N. Y.

## PEOPLE & PLACES

CALIFORNIA: **Dr. George Tarjan,** superintendent of Pacific State Hospital, Pomona, has become a member of the National Advisory Mental Health Council of the U. S. Public Health Service.

PENNSYLVANIA: **Dr. Warren J. Muhlfelder** is the new superintendent of Hollidaysburg State Hospital.

NEW YORK: **Dr. R. R. Luttrell** has been named to fill the newly created post of special assistant to the medical director at Hillside Hospital, Glen Oaks. Dr. Luttrell will continue his duties as director of the hospital's outpatient services.

**Dr. Stephen M. Smith** has been appointed director of Gracie Square Hospital in New York.

**Dr. Helen E. Elliott,** deputy assistant commissioner of the Department of Mental Hygiene, recently retired after more than 25 years of state service.

HERE & THERE: **Miss Paula L. Hesselschwerdt** has joined the staff of the Kentucky Dept. of Mental Health as psychiatric social work consultant.

Northern State Hospital at Sedro-Woolley, Washington, has a new superintendent. He is **Dr. William D. Voorhees** who has been director of the hospital's outpatient services division since 1956.

**Dr. Francis J. Gerty,** professor of psychiatry and head of the Department of Psychiatry, University of Illinois, Chicago, and past president of the A.P.A,. has been appointed director of the Illinois Dept. of Public Welfare.

HONORS: **Dr. Arthur H. Ruggles,** the first superintendent of Bradley Hospital, Providence, R. I., and past president of the A.P.A., was recently honored by having Bradley's new recreational and treatment building dedicated to him.

**Dr. Francis H. Sleeper,** superintendent of the Augusta State Hospital, Maine, was named 1960 winner of the Roselle W. Huddilston Medal. This award is given each year by the Maine Tuberculosis and Health Association to a citizen of Maine who has provided "distinguished service and outstanding contributions in the field of health to the people of the state."